

# DOCUMENT SECTION

## ARMY MEDICAL LIBRARY

[No. 152]

SUBCOMMITTEE HEARINGS ON H. R. 3254, TO PROVIDE ADDITIONAL INDUCEMENTS TO PHYSICIANS AND SURGEONS TO MAKE A CAREER OF THE UNITED STATES NAVAL SERVICE, AND FOR OTHER PURPOSES, AND H. R. 3174, TO PROVIDE FOR THE PROCUREMENT OF PHYSICIANS AND SURGEONS IN THE MEDICAL DEPARTMENT OF THE ARMY, AND FOR OTHER PURPOSES

HOUSE OF REPRESENTATIVES,  
COMMITTEE ON ARMED SERVICES,  
SUBCOMMITTEE No. 10, PAY AND ADMINISTRATION,

Monday, June 2, 1947.

The subcommittee met at 10 a. m., Hon. William W. Blackney, chairman, presiding.

Mr. BLACKNEY. The committee will be in order.

We are meeting this morning to conduct joint hearings on two bills, H. R. 3174, an Army bill; and H. R. 3254, a Navy bill—both to provide, among other things, for increasing compensation for doctors in the Army and Navy.

(H. R. 3174 and H. R. 3254 and the reports are as follows:)

[H. R. 3254, 80th Cong., 1st Sess.]

A BILL To provide additional inducements to physicians and surgeons to make a career of the United States naval service, and for other purposes

*Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That this Act may be cited as the "Naval Medical Officer Procurement Act of 1947."*

### TITLE I

#### PAY OF PHYSICIANS AND SURGEONS

SEC. 101. The Pay Readjustment Act of 1942 (56 Stat. 359); as amended, is hereby further amended by inserting after section 1 thereof the following new section:

"SEC. 1A. (a) The term 'commissioned officers of the Navy Medical Corps', as used in this section, shall be interpreted to mean only (1) those commissioned officers of the Medical Corps of the Regular Navy who are on active duty on the effective date of this amendment; (2) those officers who are commissioned in the Medical Corps of the Regular Navy during the five-year period immediately following the effective date of this amendment; (3) those commissioned officers of the Medical Corps of the Naval Reserve who are on active duty on the effective date of this amendment; and (4) such officers, now or hereafter commissioned in the Medical Corps of the Naval Reserve, as may, during the five-year period immediately following the effective date of this amendment, volunteer for extended active duty of one year or longer.

"(b) In addition to any pay, allowances, or emoluments that they are otherwise entitled to receive, commissioned officers of the Navy Medical Corps shall be paid the sum of \$100 for each completed month of active service: *Provided*, That such sum shall not be included in computing the amount of increase in pay authorized by any other provision of law or in computing retired pay: *And provided further*. That the total amount which may be paid to any one officer under the authority contained in this section shall not exceed \$36,000."

SEC. 102. This title shall become effective on the first day of the first calendar month following its enactment, and the payments herein provided shall not accrue for any period prior thereto.

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## TITLE II

## PAY OF MEDICAL AND SURGICAL SPECIALISTS

SEC. 201. The Pay Readjustment Act of 1942 (56 Stat. 359), as amended, is hereby further amended by inserting after the new section provided by section 101 of this Act the following additional new section:

"SEC. 1B. (a) The Surgeon General of the Navy is hereby authorized to designate as specialists qualified commissioned Medical Corps officers of the Regular Navy and of the Naval Reserve who are certified as specialists by an American Specialty Board recognized by the said Surgeon General. Officers so designated under the provisions of this section shall retain such designation, with the additional pay incident thereto, until it is withdrawn by the Surgeon General of the Navy: *Provided*, That no such designation shall be withdrawn while the officer concerned is on active duty until it has been determined by a board of specialists, appointed by the Surgeon General of the Navy, that such officer is no longer qualified or required in a specialty. The Secretary of the Navy is hereby authorized to prescribe from time to time such regulations as may be necessary for the administration of this section.

"(b) Medical Corps officers of the Regular Navy and of the Naval Reserve designated as specialists pursuant to the provisions of subsection (a) hereof shall receive an increase of 25 per centum of their base and longevity pay while on active duty: *Provided*, That such increase in pay shall not be included in computing the amount of increase in pay authorized by any other provision of law or in computing retired pay: *And provided further*, That if such officers are entitled by other provision of law to receive an increase in pay for participation in aerial flights, they shall elect to receive either the increase herein provided or the increase for participation in aerial flights, and in no event shall they receive both increases at the same time."

SEC. 202. This title shall become effective on the first day of the first calendar month following its enactment, and no back pay for any period prior thereto shall accrue by reason of its enactment.

## TITLE III

## ORIGINAL APPOINTMENTS OF MEDICAL AND SURGICAL SPECIALISTS

SEC. 301. The President, by and with the advice and consent of the Senate, is hereby authorized to make original appointments to permanent commissioned grades, with rank not above that of captain, in the Medical Corps of the Navy in such numbers as the needs of the service may require. Such appointments shall be made only from civilian medical and surgical specialists who have been certified as specialists by an American Specialty Board recognized by the Advisory Board for Medical Specialists and by the Surgeon General of the Navy, who are citizens of the United States, and who shall have such other qualifications as the Secretary of the Navy may prescribe. The physicians and surgeons so appointed shall be carried as additional numbers in rank, but shall not increase the authorized number of commissioned officers of the Medical Corps of the Regular Navy.

SEC. 302. The Secretary of the Navy is authorized to prescribe from time to time such regulations as may be necessary for the administration of this title.

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[No. 110]

TO PROVIDE FOR THE PROCUREMENT OF PHYSICIANS AND SURGEONS IN THE MEDICAL CORPS OF THE ARMY AND FOR OTHER PURPOSES (H. R. 3174). MR. ANDREWS OF NEW YORK

WAR DEPARTMENT,  
Washington, D. C., April 17, 1947.

The SPEAKER,  
*House of Representatives.*

DEAR MR. SPEAKER: There is inclosed herewith a draft of a bill to provide for the procurement of physicians and surgeons in the Medical Corps of the Army and for other purposes, which the War Department recommends be enacted into law.

This bill embodies the specific recommendations made by the Secretary of War's Medical Advisory Committee. This committee is made up of outstanding leaders in civilian medicine who served as professional consultants to the Surgeon General and in the various overseas theaters during the war.

Title I would amend the Pay Readjustment Act of 1942, as amended, by providing a \$1,200 increase in the base and longevity pay of officers of the Medical Corps who have less than 30 years active Federal commissioned service. The increase in pay would not be included in computing the amount of increase in pay provided by any other provision of law nor would it be counted in the computation of retired pay. Title II would amend the Pay Readjustment Act by providing a 25 percent increase in the active duty base and longevity pay of officers of the Medical Corps who are designated as specialists by the Secretary of War. The increase in pay provided by this title would not be included in computing the amount of increase in pay provided by any other provision of law and such increase would not be counted in the computation of retired pay. The increase of pay would not be paid concurrently with flight, parachute, or glider pay. Officers could be designated as specialists if they are certified as specialists by an American Specialty Board, recognized by the Advisory Board for Medical Specialists, and by the Surgeon General. Title III would establish in the Medical Department of the Army four professorships to be appointed by the President with the advice and consent of the Senate. The four professors would have the title and status of professor and the rank by assimilation of brigadier general or major general.

The President could terminate at any time the appointment of any professor. Professors not appointed from the Regular Army whose appointments are terminated prior to completion of 2 years' service as professor would receive severance pay equal to 2 months' active duty pay multiplied by the years of service as professor, any fractional part of a year amounting to 6 months or more would be counted as a full year for purposes of computing severance pay. A professor not appointed from the Regular Army with more than 2 years' service as professor at the time of termination would be retired in the grade held at the time of such termination and with retired pay equal to 2½ percent of active-duty pay multiplied by the number of years by which his age exceeds 28 years. Such retired pay could not exceed 75 percent of active-duty pay. Except as noted above professors would be retired or separated as now or hereafter provided for retirement or separation of Regular Army officers. Title IV would permit the President by and with the advice and consent of the Senate to appoint and commission in the Medical Corps of the Regular Army certain physicians and surgeons qualified as specialists in a grade, not to exceed that of colonel, appropriate to their special qualifications. Title V would authorize the Secretary of War to employ, without regard to civil-service requirements, civilian physicians to serve with the Medical Department at annual salaries ranging from \$3,640 to \$9,800 per annum. Provision is made for designation as specialist with an increase of 25 percent of such pay. No one would receive more than \$11,000 per annum. The Secretary of War would be authorized to prescribe the hours and conditions of employment and leaves of absence of persons employed under this title. The Secretary of War would be authorized to employ without regard to the Classification Act of 1923, as amended, physicians and surgeons on a temporary full-time, part-time, or fee basis.

Title I in providing additional compensation for Medical Corps officers will facilitate the procurement of physicians in the Medical Corps of the Regular Army and of the Reserve components. Without providing some additional compensation, the Army will be unable to meet the existing competition of civilian medical practice. The increase of \$1,200 per year is deemed necessary to reimburse the Medical Corps officer for the cost of his extensive professional education and loss of earnings during such education, and to bring his earnings into line with those of promotion list officers over a 30-year period. An example of the current trend in the procurement of physicians is evident upon examination of the War Department's first integration program for the Regular Army. Of 110,000 applications received, 510 medical officers applied and of these only 210 were commissioned.

Title II would assist in the procurement of Medical Corps specialists. The procurement of medical specialists is an acute problem. Many civilian doctors are now specialists in some medical specialty and are so certified by an appropriate American Specialty Board. The civilian income of these recognized specialists is much higher than that of general practitioners. Without providing some additional compensation for specialists, the Army will be unable to meet the competition of civilian practice. The Veterans' Administration has taken advantage of the act of January 3, 1946, Public Law 293, Seventy-ninth Congress, which authorizes 25

percent additional pay for qualified medical specialists. The proposed legislation offers remuneration on a basis comparable to civilian practice. The Secretary of War's Medical Advisory Committee, which is composed of the outstanding men in the medical field today, strongly recommends that such action be taken in increasing pay of Medical Corps specialists.

Appointments of Medical Corps specialists at ages over 45 and in grades higher than major, as provided by title IV, will assist in the procurement of outstanding specialists. The Secretary of War's Medical Advisory Committee feels that it would be impossible for the Medical Corps, Regular Army, to obtain any outstanding, highly competent specialists from civilian life if their rank were limited to that of major. It is believed that necessary recognition be given to professional attainments, and that such attainments should be considered in designating the grade in which specialists are appointed in the Regular Army.

Employment of civilian physicians under title V is deemed necessary in the event that the War Department is unable to secure an adequate number of qualified physicians in a military status. These physicians will be used not only as consultants, but will actually participate in the treatment of patients. In addition, they will formulate professional policies and participate in or conduct teaching programs. The Secretary of War's Medical Advisory Committee was very strong in its belief that without the assistance of civilians in the present emergency, the Medical Department cannot possibly discharge its responsibilities adequately. The extent to which civilians must actually assume a portion of the work load as attending physicians and surgeons will be determined by the rate of integration of competent officers in the Medical Corps. This title is comparable to Public Law 293, Seventy-ninth Congress, cited above.

It is estimated that the annual cost to the Government will be approximately as follows:

Title I, \$3,300,000 based on an assumed strength of 2,750 officers in the Medical Corps.

Title II, \$950,000 based on an assumption that 30 percent, or 825 officers of the Medical Corps, will qualify as specialists.

Title III, \$38,500 for the first fiscal year.

Title IV. The War Department is unable to estimate accurately the increased cost to the government since it is not known how many specialists will be appointed pursuant to this title, nor is it known in what grades they will be appointed.

Title V. The War Department is unable to estimate accurately the increased cost to the Government, since the number and pay grades of the civilians to be appointed pursuant to this title is not known.

The Bureau of the Budget has been consulted and advises the War Department that, "subject to your consideration of the advisability of revising the proposal legislation to limit the \$100 monthly increase in compensation for 30 years to those officers already in the service or those who enter the service during the 5 years following the enactment of the legislation, there would be no objection by this office to the presentation of the proposed legislation for the consideration of the Congress."

Respectfully,

ROBERT P. PATTERSON,  
*Secretary of War.*

[H. R. 3174, 80th Cong., 1st sess.]

A BILL To provide for the procurement of physicians and surgeons in the Medical Department of the Army, and for other purposes

*Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,*

## TITLE I

### PAY OF PHYSICIANS AND SURGEONS

SEC. 101. The Pay Readjustment Act of 1942, as amended, is hereby further amended by inserting the following section immediately following section 1 thereof:

"SEC. 1A. (a) The term 'commissioned officers of the Medical Corps' as used in this section shall mean commissioned officers of the Medical Corps of the Regular Army, general officers appointed from the Medical Corps of the Army,

professors of the Medical Department of the Army, and commissioned officers of the Medical Corps of the Officers' Reserve Corps, the National Guard, and the Army of the United States, who volunteer for extended Federal active duty for a period of one year or longer.

"(b) Effective the first day of the first calendar month following enactment of this section, the active duty base and longevity pay of each commissioned officer of the Medical Corps with less than thirty years active Federal commissioned service shall be increased by \$1,200 per year: *Provided*, That such increase in pay shall not be included in computing the amount of increase in pay provided by any other provision of law; and that such officers entitled, while on active duty, to the increase in pay provided for herein shall not be entitled to count such increase in the computation of their retired pay: *Provided further*, That payments under this section shall be in addition to any pay, allowances, and emoluments which the recipients are entitled to receive under any other law or regulation. No back pay shall accrue to any person by reason of the enactment of this section."

## TITLE II

### PAY OF MEDICAL CORPS SPECIALISTS

SEC. 201. The Pay Readjustment Act of 1942, as amended, is hereby further amended by inserting the following section immediately following the section provided by title I of this Act:

"Sec. 1B. (a) The Secretary of War is authorized to designate as specialists qualified commissioned officers of the Medical Corps of the Regular Army, general officers appointed from the Medical Corps of the Regular Army, and professors of the Medical Department of the Army. Officers may be designated as specialists pursuant to this section if they are certified as specialists by an American Specialty Board, recognized by the Advisory Board for Medical Specialties, and by the Surgeon General of the Army. Commissioned Medical Corps officers of the Army, other than those of the Regular Army, may also be designated as specialists under the provisions of this section.

"(b) Officers designated as specialists under the provisions of this section shall retain such designation with the additional pay incident thereto until the designation is withdrawn by the Surgeon General of the Army. No such designation shall be withdrawn while the officer concerned is on active duty until it has been determined by a Board of Specialists appointed by the Surgeon General of the Army that such officer is no longer qualified in a specialty.

"(c) In addition to the pay and allowances otherwise provided by law, any officer designated as a specialist under the provisions of this section shall receive an increase of 25 per centum of his base and longevity pay while on active duty: *Provided*, That such increase in pay shall not be included in computing the amount of increase in pay provided by any other provision of law: *Provided further*, That such increase in pay shall not be paid to any officer concurrently with the increase in pay authorized by law for personnel required to perform aerial flights, parachute jumps, or glider flights, but any such officer shall be entitled to receive either the increase herein provided or the increase which he may be entitled to receive for performance of aerial flights, parachute jumps, or glider flights, which ever is the greater.

"(d) Officers entitled, while on active duty, to the increase in pay provided for herein shall not be entitled to count such increase in the computation of their retired pay. No back pay shall accrue to any person by reason of the enactment of this section. The Secretary of War is authorized to prescribe from time to time such regulations as may be necessary in the administration of this section. The increase in pay provided by this section shall commence on the first day of the first calendar month following the designation as specialist pursuant to this section."

## TITLE III

### FOUR PROFESSORSHIPS

SEC. 301. There are hereby established in the Medical Department of the Regular Army four professorships in medicine, surgery, neuropsychiatry, and preventive medicine. Persons to fill such professorships may be appointed by the President of the United States, by and with the consent of the Senate, and will serve at schools, medical centers, teaching hospitals, and other Medical Department installations and as consultants to the Surgeon General under such regulations as the Secretary of War may prescribe.

SEC. 302. Persons appointed under this title shall be male citizens of the United States who hold the degree of doctor of medicine from approved colleges and universities. Such persons shall have the title and status of professor, and shall have the grade, by assimilation, of brigadier general or major general to be determined by their appointment: *Provided*, That nothing herein contained shall be construed to prevent reappointment of professors from the assimilated grade of brigadier general to the assimilated grade of major general.

SEC. 303. The four professors of the Medical Department shall receive the pay and allowances now or hereafter provided by law for commissioned officers of the Regular Army of the same grade. They shall not be promotion-list officers.

SEC. 304. (a) The President may terminate at any time the appointment of any professor.

(b) Professors not appointed from officers of the Regular Army and whose appointments are terminated prior to their having served two years as professors shall be separated with severance pay equal to two months' active-duty pay multiplied by the years of service as a professor, any fractional part of a year amounting to six months or more shall be counted as a full year for the purpose of determining severance pay. Professors not appointed from the Regular Army whose appointments are terminated after having served a minimum of two years as professors shall be retired in the grade held at the time of termination of appointment with annual pay equal to  $2\frac{1}{2}$  per centum of his active-duty pay multiplied by the number of years by which the professor's age shall exceed twenty-eight years: *Provided*, That the retired pay of a professor shall not exceed 75 per centum of his active-duty pay: *And provided further*, That in computing the amount of retired pay any fractional part of a year amounting to six months or more shall be counted as a full year.

(c) Professors appointed from the Regular Army whose appointments are terminated shall be retired or separated under laws now or hereafter prescribed for the retirement and separation of Regular Army officers. If the appointments as professors are terminated but such professors are not retired or separated, they shall be returned to the appropriate promotion or nonpromotion list of the Regular Army, and shall be placed in the same relative position that they would have occupied had their service on such list not been interrupted by appointment as professor.

(d) Except as provided by subsection (b) of this section, professors of the Medical Department of the Army not appointed from officers of the Regular Army shall be retired in the same manner and with the same retired pay as now or hereafter provided for commissioned officers of the Regular Army.

SEC. 305. Except as otherwise specifically provided herein, or obviously not applicable to this special group, all laws now or hereafter applicable to commissioned officers of the Regular Army shall be applicable in like cases to professors of the Medical Department of the Army.

#### TITLE IV

##### ORIGINAL APPOINTMENT OF MEDICAL CORPS SPECIALISTS

SEC. 401. The President by and with the advice and consent of the Senate is authorized to appoint and commission in the Medical Corps of the Regular Army physicians and surgeons who have been certified as specialists by an American Specialty Board recognized by the Advisory Board for Medical Specialties and by the Surgeon General of the Army. Such persons may be appointed in a grade not above that of colonel, appropriate to their special qualifications.

SEC. 402. Specialists appointed pursuant to this title shall be credited for purposes of promotion with the minimum number of years of service now or hereafter required for promotion of officers of the Medical Corps to the grade in which such specialists are appointed.

SEC. 403. The Secretary of War is authorized to prescribe from time to time such regulations as may be necessary in the administration of this title.

#### TITLE V

##### EMPLOYMENT OF CIVILIAN PHYSICIANS

SEC. 501. The Secretary of War is authorized to employ, without regard to civil-service requirements, civilian physicians in such numbers and for such periods of time as he may deem necessary, to serve with the Medical Department of the Army.

SEC. 502. Persons employed under this title shall be persons who hold a degree of doctor of medicine from an approved college or university, have completed an internship satisfactory to the Secretary of War, and possess such license and such professional, physical, and other qualifications as the Secretary of War may prescribe.

SEC. 503. The grades and per annum full-pay ranges for doctors employed under this title shall be as follows:

Chief grade, \$8,750 minimum to \$9,800 maximum.

Senior grade, \$7,175 minimum to \$8,225 maximum.

Intermediate grade, \$6,230 minimum to \$7,070 maximum.

Full grade, \$5,180 minimum to \$6,020 maximum.

Associate grade, \$4,300 minimum to \$5,180 maximum.

Junior grade, \$3,640 minimum to \$4,300 maximum.

SEC. 504. (a) Within the restrictions herein imposed, the Secretary of War may designate any doctor employed under this title as a medical or surgical specialist: *Provided*, That no person shall at any one time hold more than one such designation.

(b) No person may be designated as a medical or surgical specialist unless he is certified as a specialist by an American Specialty Board, recognized by the Advisory Board for Medical Specialists and by the Surgeon General of the Army.

(c) Any person designated as a specialist under the provisions of this section shall retain such designation until it has been withdrawn by the Surgeon General of the Army. No such designation shall be withdrawn until it has been determined by a Board of Specialists appointed by the Surgeon General of the Army that such person is no longer qualified or required in a specialty.

(d) Any person designated as a medical or surgical specialist under the provisions of this section shall receive, in addition to his basic pay, an allowance equal to 25 per centum of such pay: *Provided*, That in no event shall the pay plus the allowances authorized by this subsection exceed \$11,000 per annum.

SEC. 505. Notwithstanding any law, Executive order, or regulation, the Secretary of War shall prescribe by regulation the hours and conditions of employment and leaves of absence of persons employed under this title.

SEC. 506. The Secretary of War may employ without regard to the Classification Act of 1923, as amended, physicians on a temporary full-time, part-time, or fee basis: *Provided*, That no temporary full-time appointment under this section shall be for a period of more than ninety days.

SEC. 507. The Secretary of War is authorized to promulgate such regulations as are required to carry out the provisions of this title.

SEC. 508. This title shall be effective from the date of its approval.

[No. 117]

TO PROVIDE ADDITIONAL INDUCEMENTS TO PHYSICIANS AND SURGEONS TO MAKE A CAREER OF THE UNITED STATES NAVAL SERVICE, AND FOR OTHER PURPOSES  
(H. R. 3254). MR. ANDREWS OF NEW YORK

NAVY DEPARTMENT,  
Washington, April 25, 1947.

Hon. JOSEPH W. MARTIN, Jr.,

*Speaker of the House of Representatives,*

*Washington, D. C.*

MY DEAR MR. SPEAKER: There is transmitted herewith a draft of a proposed bill to provide additional inducements to physicians and surgeons to make a career of the United States naval service, and for other purposes.

The purpose of the proposed legislation is to make a career in the Medical Corps of the Navy more attractive to physicians and surgeons, whether general practitioners or specialists, and thereby enable the Medical Department of the Navy to procure additional Medical Corps officers and to retain Medical Corps officers now in the service.

Title I of the proposed bill would authorize payment of additional compensation of \$100 for each completed month of active service to those commissionel officers of the Medical Corps of the Regular Navy and of the Naval Reserve who are on active duty on the effective date of the title, to those officers who are commissioned in the Medieal Corps of the Regular Navy during a 5-year period immediately following the effective date of the title, and to such commissioned officers of the Medical Corps of the Naval Reserve as may, during a 5-year period immediately following the effective date of the title, volunteer for extended active duty for a period of 1 year or longer.

The additional pay which would be authorized by title I of the proposal, would be limited to a total of \$36,000 for any one officer. No back pay would accrue by reason of enactment of title I of the proposed legislation.

The authorized strength of the Medical Corps of the Regular Navy under present law is 4,315 officers. However, its present actual strength is only 1,825 officers, and many of these officers have submitted their resignations from the naval service. The Medical Department of the Navy is now able to function because, in addition to those Regular Navy doctors, 1,727 Reserve medical officers are still on active duty. Of this group of Reserve doctors, only 187 are retained on active duty by their own consent. The remaining 1,540 are graduates of the Navy's V-12 training program and they will all be eligible for separation from active naval service 6 months after the end of the present emergency. It is believed that few, if any, of these Reserve doctors will apply for transfer to the Regular Navy under present conditions. Therefore, it is obvious that unless some effective measure is adopted immediately which will enable the Navy to retain the Regular Navy medical officers it now has and to procure additional medical officers from both the Reserves and from civilian physicians and surgeons, in the near future the Medical Department of the Navy will not have sufficient medical officers to provide adequate medical care to Navy and Marine Corps personnel.

The Navy Department has given a great deal of consideration to the problem of maintaining the Navy Medical Corps at the required strength for the postwar Navy and many plans to accomplish this result have been advanced and studied. The major plans considered are (1) to establish a medical academy for the Navy, (2) to adopt a plan of subsidizing medical education similar to the officer candidate training program authorized by the act of August 13, 1946 (60 Stat. 1057), and (3) the plan which title I of the proposed bill would authorize.

The proposal to establish a medical academy for the Navy is not considered a sound one. A large general hospital would be required in connection with a medical school as the variety of patients in naval hospitals is not considered sufficient for teaching purposes. The cost of establishing a medical academy and a general hospital is prohibitive. It is estimated that it would cost approximately \$10,000 per bed to build a modern hospital and approximately \$2,500 per year to maintain each bed. Even if this plan were put into effect, the Navy Department would not obtain any medical officers from this source for some time.

It is considered that a plan of subsidizing medical education similar to the officer candidate training program authorized by the act of August 13, 1946 (60 Stat. 1057), would be ineffective under existing circumstances as it would be at least 4 or 5 years before the Navy Department would obtain any medical officers from this source. Such a plan would offer inducements to young men to prepare for a career in the naval service, but it would not increase the attractiveness of the career once it is entered upon. Although officers procured from this source would be compelled to remain in the service for a certain period of time, experience with the Navy's V-12 training program indicates that they may be expected to leave the service as soon as their obligations to the service are fulfilled.

It is believed that a plan similar to the Navy's officer candidate training program would not meet with favorable response from medical schools. At the present time, medical schools are able to accommodate approximately one out of five applicants for admission. These schools are not in a position to enlarge their present enrollment to meet any increase in the number of students that might become necessary should such a plan be adopted. It is believed that State-supported medical schools particularly would be reluctant to support such a program. State medical schools are established and maintained primarily for the purpose of training medical students who are citizens of the State concerned and, who, after graduation, usually practice their profession in their home State. Therefore, it is only reasonable to assume that, if such a plan were adopted, citizens of a State would be given preference in filling the limited number of vacancies in the enrollment of that State's medical school.

Even though a candidate is selected for training and sent to a medical school at Government expense, there is no assurance that he will be able to complete his medical education and be commissioned in the Medical Corps of the Regular Navy. And when the candidate is commissioned, there is still the problem of integrating the officer into a successful naval career.

It is believed that the plan contained in title I of the proposed legislation is the most desirable plan in that it would produce immediate results. First, such a plan would tend to eliminate in some measure the great volume of resignations from the Regular Navy Medical Corps that is being received. Second, it is believed that the increase in pay offered by the plan would induce a substantial

number of the Reserve medical officers now on active duty to transfer to the Regular Navy or to remain on active duty for additional periods of time after they become eligible for release to inactive duty. Third, it is also believed that the plan would attract young doctors who graduate from medical schools during the 5-year period following the effective date of title I of the proposed legislation. It is the most economical plan since the payment would be made only to officers who have proved their worth and their desirability for duty in the Medical Corps of the Navy. It maintains the democratic principle of taking candidates from all approved medical schools and from all sections of the country, and keeps the members of the Medical Corps of the Regular Navy in closer touch with all the medical schools and the civil profession.

Title II of the proposed legislation would make a career in the Medical Corps of the Navy more attractive to medical and surgical specialists by authorizing the Surgeon General of the Navy to designate an officer of the Medical Corps of the Regular Navy or of the Naval Reserve as a specialist when the officer has been so certified by an American specialty board recognized by the Surgeon General of the Navy. A medical officer designated as a specialist would receive an increase in pay amounting to 25 percent of his base and longevity pay during the period that he is on active duty as a specialist. The specialty pay which would be authorized by the proposed bill would not be included in computing the amount of increase in pay under any other provision of law or in computing retired pay. Any officer entitled to receive specialty pay who is also entitled to aerial flight pay would not be permitted to receive both increases but would be required to elect between the two.

As stated above, the authorized strength of the Medical Corps of the Regular Navy at present is 4,315 officers. The best available data indicate that approximately 30 percent of this number of officers should be medical and surgical specialists if the Medical Corps of the Navy is to furnish adequate medical care to Navy and Marine Corps personnel. However, the actual number of specialists now in the Medical Corps of the Regular Navy, including prospective specialists doing postgraduate work, is only 115.

The services of additional medical and surgical specialists were obtained during the war from civilian sources through the Naval Reserve. However, since Naval Reservists can be called to or retained on active duty in time of peace only by their own consent, the Navy must now obtain its specialists from the civilian profession by appointment to commissioned rank in the Medical Corps of the Regular Navy.

In the civilian practice, the income of specialists in the various branches of medicine is considerably more than that of a general practitioner. The Congress has recognized this condition, and by section 8 of the act of January 3, 1946 (59 Stat. 677), has authorized 25 percent additional pay for qualified medical and surgical specialists in the medical service of the Veterans' Administration. The Navy Department believes that a similar inducement must be provided for Navy medical and surgical specialists if the Navy is to compete successfully in procuring qualified specialists. Such an inducement would not only be an incentive for civilian medical and surgical specialists to seek a career in the Navy, but who would also serve as a stimulus to doctors in the service who are qualified specialists to remain in the Navy.

Title III of the proposed legislation would authorize the President, by and with the advice and consent of the Senate, to appoint civilian medical and surgical specialists to permanent commissioned grades in the Medical Corps of the Navy with ranks up to and including the rank of captain. A specialist appointed under the authority of this title would be required to be certified as a specialist in his particular field by an American specialty board recognized by the Advisory Board for Medical Specialists and by the Surgeon General of the Navy. Appointees would also be required to be citizens of the United States and to have such other qualifications as the Secretary of the Navy may prescribe. The medical officers appointed under the provisions of this title would be carried as additional numbers in rank but the authorized number of commissioned officers of the Medical Corps of the Regular Navy would not be increased.

Under present law, all original appointments to commissioned rank in the Medical Corps of the Navy, other than those appointments made from transferees from the Naval Reserve, are made either in the grade of acting assistant surgeon or assistant surgeon with the rank of lieutenant (junior grade). These appointees have completed all or most of their professional training, but they have not had sufficient training or experience for designation as medical or surgical specialists. Therefore, the necessary additional specialists to fill the immediate needs of the Navy cannot be procured under the authority of present law.

Title III of the proposed bill would enable the Navy Department to obtain the needed specialists from the civilian profession, and to appoint them to a rank commensurate with their special qualifications and experience.

The Navy Department, accordingly, recommends enactment of the proposed legislation.

Based upon the authorized strength of the Navy Medical Corps, or 4,314 officers, it is estimated that enactment of title I of the proposed bill would result in an annual additional cost of \$5,178,000 to the Government.

It is estimated that enactment of title II of the proposed legislation will result in an additional cost of \$138,000 for the fiscal year 1948. Even with the additional inducements that the proposed bill would provide, it is believed that it will be several years before the Navy will obtain the required number of specialists. Since the additional specialists that may be commissioned in the Navy during each fiscal year subsequent to the fiscal year 1948 cannot now be determined, the Navy Department is unable to make any worth-while estimate of the annual cost of the proposed legislation beyond the fiscal year 1948.

Enactment of title III of the proposed legislation would result in no additional cost to the Government, since officers appointed under the authority of this title would be within the ceiling of medical officers otherwise prescribed by law.

The Navy Department has been advised by the Bureau of the Budget that there is no objection to the submission of this report to the Congress.

Sincerely yours,

JOHN L. SULLIVAN,  
*Acting Secretary of the Navy.*

Mr. BLACKNEY. Title I of the Army bill provides that the active duty base and longevity pay of each commissioned officer of the Medical Corps with less than 30 years' active Federal commissioned service, shall be increased by \$1,200 per year. It applies to all commissioned officers of the Regular Army and general officers appointed from the Medical Corps of the Army, professors of the Medical Corps of the Army, and commissioned officers of the Medical Corps of the Officers' Reserve Corps, the National Guard, and the Army of the United States, who volunteer for extended Federal active duty for a period of 1 year or longer.

Title I of H. R. 3254, the Navy bill, provides that, in addition to any pay, allowances, and so forth, commissioned officers of the Navy Medical Corps receive, they shall be paid an additional sum of \$100 for each completed month of active service, with a limit of the total amount which any officer may receive under authority of this title, of \$36,000. It applies to all commissioned officers of the Regular Navy who are on active duty on the effective date of the enactment of this bill and to all officers who were commissioned in the Medical Corps of the Regular Navy during the subsequent 5-year period following the adoption of this bill and all commissioned officers of the Medical Corps or the Naval Reserve who are on active duty on the effective date of this bill, as well as to such officers now or hereafter commissioned in the Medical Reserve as may during the next 5-year period volunteer for extended active duty for 1 year or longer.

Title II of the Army bill provides for an increase of 25 percent of the base and longevity pay of any Army doctor who is designated as a specialist, except that such an officer must elect between this increase and flight pay, paratrooper's pay, or glider's pay, as the case may be.

Title II of the Navy bill is very similar to the Army bill, except that the election as to the 25-percent increase or extrahazardous-duty pay applies only to flight pay.

Title III of the Army bill provides for the establishment in the Medical Department of the Regular Army of four professorships,

with appointment by the President, who shall if they are civilians, have the assimilated grade of brigadier general or major general, and provides further that if they are appointed from civilian life and serve for more than 2 years, they shall be retired in the grade held at the time of the termination of their appointment, with annual pay equal to 2½ percent of their active-duty pay multiplied by the number of years by which the professor's age may exceed 28 years, provided it may not exceed 75 percent of his base pay. There is no similar provision in the Navy bill.

Title IV of the Army bill authorizes the President, by and with the consent of the Senate, to commission doctors in the Regular Army, as specialists from civilian life, up to the grade of colonel. This is analogous to title III of the Navy bill.

Title V of the Army bill provides for the employment of civilian physicians without regard to civil-service requirements, and provides in addition that specialists shall receive a 25-percent increase, providing only that their salary does not exceed \$11,000 per annum.

It also provides that the Secretary of War may employ, without regard to the Classification Act of 1923, physicians on a temporary, full-time, part-time, or fee basis. There is no similar provision in the Navy bill.

It therefore appears that basically the two services appear before us today to request legislation which they feel is necessary in order to maintain the Medical Corps of the Army and Navy. While the bills are similar in some provisions, it is of course obvious that the Army bill is more extensive than the Navy bill.

We will call as our first witness Secretary Patterson.

#### **STATEMENT OF HON. ROBERT P. PATTERSON, SECRETARY OF WAR**

Secretary PATTERSON. In April 1945 my distinguished predecessor, Mr. Stimson, in an official statement adopted the position that the Secretary of War should consider himself directly responsible for the medical care of the Army. It was his feeling that, as the representative of an elected administration, he owed this to the men themselves and to their families. In these matters I have followed in Mr. Stimson's footsteps and have been actively personally interested in Army medicine. The highest standard of medical care ever attained in any army in the world was reached in our forces in the recent war. Deaths from illness were reduced to an almost infinitesimal percentage, six-tenths per 1,000 men per year—even compared with World War I, 16 per 1,000 men per year, where our medical care was good. The percentage of deaths among the wounded who reached medical attention was more than cut in half from World War I. This was possible only because we had the services of 47,000 of the ablest civilian doctors, who formed numerically 97 percent of our Army Medical Corps. After the war, these men, almost without exception, returned to civilian life. Since then, medical care of the Army has been possible primarily through the service of graduates of the Army specialist training program, who received their medical education during the war at Government expense, and who are now serving tours of duty in the Army of two years. Many of these men had postgraduate training beyond their ordinary internship. All of these men desire to return, as soon

as possible, to civilian life, and we can retain them only for 6 months after the war emergency is declared officially over.

We must, therefore, soon rely upon voluntary, not enforced, service for Army doctors. We have had two "integration" bills. These provided 1,900 vacancies for commissions in the Regular Army. Of these, it was possible to fill only 218, or about 10 percent. In branches of the Army other than medicine, there were five candidates for every commission. But in medicine there was only one applicant for every three vacancies. After losses from normal attrition, we had no gain, but actually a net loss, after integration, of 127 officers. This was in spite of the best efforts that the Army could make to attract doctors, stimulated by our clear recognition of the acute need which existed.

These results of the two integrations show convincingly that, under present conditions, an Army medical career has little appeal, and that we face an emergency. The only source for Army doctors is the civilian medical profession. There is no West Point for doctors.

I, therefore, turned for advice to leaders of the civilian medical profession, and appointed a medical advisory committee, consisting of distinguished doctors in civilian practice, who also had first-hand knowledge of Army medicine by service during the recent war. These men have no interest but that of patriotism to serve, and at great personal sacrifice made an intensive study of the situation. Their recommendations were approved in full by me as Secretary, and are expressed in the present bill. Its purpose is to attract doctors into the Army by raising the standard of medical practice in the Army. From the Army's standpoint, all of these provisions are a part of one integrated whole. This program represents the best method which we have been able to find to meet the crisis which we face in Army medicine.

The seriousness of this emergency is vividly portrayed by the fact that a questionnaire conducted by the Information and Education Division of the War Department Staff showed that, of 386 graduates of the Army Specialized Training Program selected at random, only one was interested in a regular Army career; yet these ASTP graduates constitute the best and, to a large extent, the only source from which recruits for the Army Medical Corps must come.

The details of this program and the reasons for it can be better explained by the doctors who developed it, and by the Surgeon General, and they are prepared to do so.

I might add, Mr. Chairman, simply this: This bill does give special treatment and special emoluments and benefits to Army medical officers over and above those given to other officers. For that reason, it was very closely scrutinized by the general staff, by the Chief of Staff, and by myself, because that is a practice that in general we don't like to embark on. However, it was a condition and not a theory that we faced. We saw the stiff competition now being put up by the attractions in civilian medicine. We saw the over-all shortage of medical talent in this country. We were convinced that unless a measure like this was enacted into law, we just wouldn't have any Medical Corps worthy of the name.

I would like to comment very briefly on the other features of the bill than the first feature. The bill was very accurately summarized in your opening statement, Mr. Chairman. The first section of course

gives the \$100 per month extra pay. There follow other provisions, which we believe are fully as vital as that: A provision for 25 percent extra pay for specialists, which is in accord with accepted practice throughout the country for specialists; the section to provide for professorships, which we believe, in addition to the monetary advantages that doctors would gain by taking commissions in the Medical Corps, will give an intellectual stimulus and offer to them advantages of a rounded-out medical career, by providing medical leadership; also the feature that we may commission direct from civilian life; and the feature that if necessary we can do what the Veterans' Administration have resorted to and that is to hire full time, part time, or on a fee basis civilian doctors.

As I see it, if we get into a tight pinch, with the need we have of doctors for overseas service—half of the Army is serving overseas. We have to provide medical attention to far-away places, such as Germany, Austria, Japan, and Korea. We have to use Army doctors for that. We cannot use civilians adequately for that service, but civilian doctors taken on a hired basis, whether full time, part time, or fee, can in such an event be worked in advantageously to our general hospitals, among others, in this country.

If we have to resort to it—and we may have to—that provision will go a considerable distance toward satisfying our requirements, providing for service in a hospital like Walter Reed, in this city. It is conceivable that almost every medical officer we have will have to serve outside the country. Then the void or vacuum that is created in this country can be filled, by such a provision as that.

I am gratified that the two bills, the Army bill and the Navy bill, are, I believe, in substantial accord. They differ in details, taking into account the needs for the two services, but in the main I think they come into close agreement.

Now, if there is any desirable feature of their bill that we should take, in lieu of something in ours, that is all to the good and we are glad to do it. If on the other hand there is something in our bill that upon serious reflection the Navy think they would like to have, we would be glad to have those extended to the Navy bill, too.

There is no purpose here at all of one service trying to take a competitive advantage of the other, not in the least.

Mr. BLACKNEY. Thank you, Mr. Secretary, for that statement.

I want to ask you two or three questions.

Why does title I of the Army bill apply only to doctors with less than 30 years' active Federal commissioned service?

Secretary PATTERSON. I suppose that is because that is considered the useful period of their lives. Can you tell me that, General Bliss?

General BLISS. Our bill was written with the thought that ordinarily Army officers can retire at the end of 30 years. It was considered that going over that would not necessarily be particularly desirable, although we agree more fully with the Navy bill, as a matter of fact. Under the Navy bill, all of our men who have had over 30 years' service—and there are very few in the Army—would get the \$100 a month. Under our bill, it would stop when you would reach 30 years' service. We are perfectly willing to accept the Navy bill. We think it is better. There will only be a very few affected. We stopped at 30 years, because ordinarily Army life stops and people retire after that period of service.

Mr. BLACKNEY. Do I understand that this bill permits an additional 5 percent for each 3 years of active duty, to be applied to the \$1,200 increase, in the form of longevity pay?

General BLISS. No, sir; it does not. That is entirely separate. It doesn't count for anything else at all, except that. It isn't carried over on retirement. It is a straight \$100 a month and is not considered there in any way. There is no percentage going on there for that.

Mr. BLACKNEY. Another question. Do I understand that this bill does not apply to reserve officers on active duty who do not volunteer for extended duty for 1 year or more?

General BLISS. That is correct; yes, sir.

Mr. BLACKNEY. That is correct?

General BLISS. Yes, sir.

Mr. BLACKNEY. Does this bill apply to retirement pay?

General BLISS. No, sir.

Mr. BLACKNEY. It does not?

General BLISS. It does not; no, sir.

Mr. BLACKNEY. I want to ask this question: Does the Army have a medical center to teach its doctors?

Secretary PATTERSON. General?

General BLISS. Yes, sir; the Army does. We have schools at numbers of places, where we are attempting to teach doctors.

Now, I would have to go into a little more detail on that, because at the start of the war we had some 1,200 medical officers in the Regular Army. During the war, of necessity, all of our doctors got away from professional work entirely. We all had administrative work to do, and we got away from professional work in the Army. We only had a very few—two, three, or four—doctors who stayed right on in the practice of medicine. They all got away from it for 5 or 6 years, with the result that now we have the greatest difficulty in staffing our places for professional teaching. You cannot stay out of medicine for 5 or 6 years and come back into it.

We had a very large group, due to the integration in the last war, who were all taken in at one age group, but they are now much older men and about ready to retire. We have taken in very few during the interim period between the wars. Those young men who we had in and who were getting right along to being well trained as doctors, as I say, got away for 6 years from professional work, having to run hospitals and doing all kinds of other than professional work.

Therefore, we find ourselves now with a void of people to teach our men. Our men are now, you might say, disqualified professionally, so that they can be put in teaching positions. They are good professional men, but they have been away from professional work. In time, when we can get them to doing professional work, they will again become qualified for professional teaching, but at the present time we don't have the teachers. All of our young men in the Army have to go back and be taught again. We have a residency training program going on at all of our general hospitals in the country. We have a large teaching center at Walter Reed. We have a very large teaching center at San Antonio. We have attempted to staff these centers with the very best men we can get in the Regular Army and, at the present time, with consultants that we can obtain from the outside.

Does that answer your question, Mr. Chairman?  
 Mr. BLACKNEY. Why is this bill confined to doctors?

General BLISS. Sir?  
 Mr. BLACKNEY. Why is this bill confined to doctors, rather than other professional groups?

Secretary PATTERSON. We had no trouble getting applicants for Regular Army commissions from any of the other professional groups, or line officers, or Ground Force officers, or Air Force officers. The whole trouble came in the Medical Corps, where we were unable to get prospects.

I take it that that reflects a condition prevalent also in civilian life in this country. I have never heard of a shortage of lawyers in the country, or really no shortage of engineers, either, although it is often said that there is.

We have to distinguish, Mr. Chairman, between these different fire alarms. I have heard many, many, fire alarms, many of them without any real fire at all. This is a real fire. It has been shown by every test that we have applied to the situation. I refer to the questionnaire that was sent out. Of course, even more telling than that is the fact that we were only able to get, out of a 1,900 quota, something like 200 officers.

Mr. BLACKNEY. Mr. Secretary—

Secretary PATTERSON. Then, of course, we have lost by resignation a good many of our prewar Regular Army Medical Corps officers, something like two or three hundred, and that out of a total force of 1,300 prewar Medical Corps officers is a severe loss.

I am told the Navy is in the same case—the condition is chronic—but I don't know the details of that. There are people here from the Navy who do, and they can elaborate on that. It seems to me an unfortunate condition that both services are subject to.

Mr. BLACKNEY. Mr. Secretary, you think the shortage of physicians and surgeons in the War Department is certainly a serious proposition?

Secretary PATTERSON. Extremely serious. A year from now I don't know where we are going to get any Medical Corps. A year from now the great bulk of these youngsters that are now serving and are giving us the medical care that we can provide will be out. They will have completed their 2 years compulsory service, even though the war and 6 months has not expired, and where we are going to provide the Army with any medical care for just ordinary peacetime conditions I confess I don't see unless we can enact a measure like this and offer them better attractions and recruit them from civilian practice.

Mr. GAVIN. May I ask a question?

Mr. BLACKNEY. Mr. Gavin.

Mr. GAVIN. How many boys did we train in the Army Specialist Service?

Secretary PATTERSON. About 10,000, I think.  
 General BLISS. Nine thousand.

Mr. GAVIN. Nine thousand?  
 General BLISS. Yes, sir.

Secretary PATTERSON. A lot of them are already out.

Mr. GAVIN. How many years of training did we give them?

Secretary PATTERSON. We gave them at least their period in medical school. Some of them got a junior residency of 9 months, and some

got a senior residency of 9 months. I think the period varied from 4 years to 7 years—isn't that about right?

General BLISS. From 2 years to 7 years, sir.

Mr. GAVIN. How much of an investment did we make in each boy's education, approximately?

Secretary PATTERSON. A very big one.

Mr. GAVIN. Well, what would you say, approximately?

General BLISS. \$10,000 to \$15,000. ~

Secretary PATTERSON. How much?

General BLISS. \$10,000 to \$15,000.

Mr. GAVIN. And thereafter they serve but for 2 years?

General BLISS. Yes, sir.

Secretary PATTERSON. That can be terminated, of course, by termination of the war and 6 months.

Mr. GAVIN. Yes.

Secretary PATTERSON. Then it would be shorter than 2 years.

Mr. GAVIN. And you say you are making an effort to secure some 1,800 doctors having only been able to secure thus far some 280 or thereabouts?

Secretary PATTERSON. That is right.

Mr. GAVIN. And we educated some 9,000 or 10,000 youths in the medical profession?

Secretary PATTERSON. That is right. That is the Army share. The Navy had some, too.

Mr. GAVIN. It seems to me that we should have made some provision to secure a greater period of service, in view of the \$15,000 cost of their education.

Secretary PATTERSON. That is possible—

Mr. GAVIN. When a boy comes out of the Military or Naval Academy, how long does he stay in the service? I mean, he is required to stay in the service a certain period of time, isn't he?

Secretary PATTERSON. Yes, sir. Do you know what that is?

General BLISS. Two years.

Secretary PATTERSON. Two years.

Mr. GAVIN. Only 2 years?

Secretary PATTERSON. Yes.

Mr. GAVIN. Well, if we are going to expend that amount of money on the educational training of these youths, certainly we ought to require them to serve a greater period of service in view of the evident shortage of doctors.

Mr. BLACKNEY. Mr. Cole?

Mr. COLE. Mr. Secretary, is there any fire signal in regard to dentists?

Secretary PATTERSON. No. We may have an emergency situation there, too, but it hasn't developed to date to the degree that the situation regarding the regular doctors has.

Mr. COLE. Has that field been as thoroughly canvassed as the medical field, or is the dental field such that its condition is not as urgent as the medical and therefore hasn't come to the attention of the War Department with the same force?

Secretary PATTERSON. I will have to ask General Bliss about that, Mr. Cole.

General BLISS. It has come to the attention of the War Department and has been given very careful study.

This was the recommendation of the Board appointed by the Secretary of War, upon which everyone is in agreement. There was a great deal of dissention about the dentists. Actually, we have gained 100 to 200 dentists, in this integration. It is not as serious a condition at the moment as the medical, but it is a serious condition. We are short of dentists. We had thought—and the committee apparently thought—that all the cogs in the wheel of the Medical Department are most important and essential. The wheel itself is absolutely essential and we can't get along without it. The doctors are the wheel. There was no dissention at all as to this bill, by anyone who has considered it. The situation as regards dentists was controversial. We have gained dentists in our integration. However, we are losing the doctors, going down all the time. It has been very carefully studied, sir, and it is conceivable that something will have to be done about the dentists at some future time.

Mr. COLE. Do I understand you have more applications from the dentists than you currently have need for?

General BLISS. No, sir; we had a strength in the Dental Corps before the war of 350. We have succeeded in keeping most of those dentists that we had in. In addition, we have gained 100 to 200 in this integration. On the other hand, of some 30,000 officers, whom the Congress authorized to be integrated into the Regular Army—just to digress a little from what the Secretary said—there were 163,000 applications. We had fewer than 800 in ours, and there was something like that in the Dental Corps, too. We succeeded only in getting 218. We lost 350 in the meanwhile. The dentists have not lost that number. In fact, they have gained 100 to 200. It is serious, but not as serious—

Mr. COLE. Have you any indications from the dentists now on duty that, if this increase is given to the medical people, and the dentists do not receive the increase that they are going to quit?

General BLISS. Not that they are going to quit, but they are going to try to get it, probably.

Mr. COLE. That is understandable, but their dissatisfaction in having this differential established in favor of the medical people is not so great that they, the dental people, are going to resign and leave the service?

General BLISS. We haven't had that indication, no, sir.

Mr. COLE. Thank you, General.

Mr. Secretary, the question of the bonus itself, which provides for a flat \$100 a month bonus to any medical officer, irrespective of his age or of his length of training, service, and experience, seems to be questionable.

Secretary PATTERSON. It is a flat sum. Each man gets the \$100, whether he is a first lieutenant, a major, a colonel, or what not.

Mr. COLE. Or whether he is fresh out of medical school?

Secretary PATTERSON. Yes.

Mr. COLE. And whether he has been out of medical school and practiced for a number of years, or perhaps has been in the Army for a number of years. Do you know whether the Department gave any thought to having this bonus based on a percentage of base pay, rather than on a flat dollars a month bonus?

Secretary PATTERSON. Yes; I know the Medical Advisory Committee, which originated the whole proposal, gave thorough consideration

to that and decided that the differences in age and experience were reflected by their normal pay, their base pay and longevity pay. They thought this should be a flat sum per month.

Of course, there are other precedents for that, I think, in both the Army and the Navy. I know in parachute work it is a set sum. Also in the combat infantry badge pay you have a set sum per month for each man, whether he is a private, a sergeant, or what not. It did not, however, in that case, apply to officers. They never got any money. They were allowed to wear the badge, but did not get any extra pay for it.

Mr. COLE. At any rate, the Medical Department of the Army did give consideration to a percentage allowance, rather than a flat dollar standard allowance?

Secretary PATTERSON. That is right. We will have at least two of the committee here as witnesses: Dr. Churchill and Dr. Morgan. I think they can tell you the considerations that moved them to urge the adoption of the features of this bill.

Mr. COLE. Now, would you amplify, or would you prefer to have someone else explain or amplify, this idea of the four professors? Are you sufficiently familiar with their duties?

Secretary PATTERSON. No; I think they could do it more adequately, Mr. Cole, than I could. I will confess that.

Mr. COLE. I have no other questions, except I do want to inquire more fully into those four professorships.

Mr. BLACKNEY. Mr. Hébert?

Mr. HÉBERT. Mr. Secretary, there is a thought that has been running through my mind for a great many years; that is a long-range program, in connection with both the Army and the Navy, for educating their own medical officers. This morning you have opened the door, I think, to exactly the thought I had in mind, when in your statement you said there is no West Point for doctors. I would like to have your reaction to the thought of a long-range program, admitting that this, of course, is emergency legislation. But I think we should face the future and explore the field with a long-range view. Don't you think it consistent, and don't you think it practical and desirable, that both the Army and the Navy should establish their own medical school to train their own doctors in the practice of medicine, with particular attention to those fields that are peculiar to the Navy and to the Army—for instance, gunshot wounds—

Secretary PATTERSON. That is a pretty broad field, Mr. Hébert. I would think, if it were going to be any education paid for at Government expense for future career officers along the medical line for the Army and the Navy, probably it would be better to do what was done in the war, but on a longer engagement, after completion of education. That is to say, send them to regular medical schools, ordinary medical schools, along with people who attend from civilian life. I should think probably that would be more satisfactory than setting up a special school.

Mr. HÉBERT. Well, don't you think—

Secretary PATTERSON. However, that is not a thought-out conclusion. I might be wrong on it.

Mr. HÉBERT. Well, Mr. Secretary, keeping in mind your civilian doctors after they have graduated from the school into a long-range program either in the Army or the Navy, there you have the indi-

vidual who has completed an education in medicine. Now, isn't it a fact and don't you think the field is very wide, where the young boy coming up in many instances who desires a medical education, but finds himself in a position that he does not have the financial assistance or does not have the money to enter medical school, which is a very expensive education, would develop a great many talented young men who would pursue a medical education if they had the wherewithal to attend medical school. In that field you could then enlist many, many young men who have a certain talent for medicine and who would pursue the study of medicine if they were able to obtain that education? I have that thought in mind. So many young men fall by the wayside because they just can't get their foot in the door. They can't get started.

Secretary PATTERSON. That is quite possible. Of course, this is a recent condition. For some reason, in the last 6 or 7 years, the people of the United States have been requiring, or at least getting far more in the way of medical treatment than they ever did before. The Army and the Navy never had any trouble prior to right now in getting their medical talent. They didn't have any prewar trouble in getting it, and even during the war the needs were filled by these thousands of men who came in from civilian life. But they are now leaving. Almost all of them have left, all that can. Due to spending power or an increased awareness of their need of medical service—something has brought it about whereby the time of doctors in civilian life and their earnings have been greatly increased.

Mr. HÉBERT. Of course—

Secretary PATTERSON. There are great attractions for a career in civilian medicine as contrasted with a career in Army medicine.

Mr. HÉBERT. Well, of course, don't you think the reason is quite obvious, that the Nation has become more or less health conscious? Certain thoughts have been projected into national health education and national health security. Also, you have the Veterans' Administration, which has been expanded greatly to take care of so many other individuals who heretofore were not taken care of.

Secretary PATTERSON. Right.

Mr. HÉBERT. And your own Army, taking the Army situation itself, didn't demand as much attention numerically prior to the war as it will now in the future. We are going to project ourselves into a long-range defense program.

Secretary PATTERSON. I think that is true.

Mr. HÉBERT. Then, don't you think—

Secretary PATTERSON. The trend you mentioned has been sharply accelerated just in the last few years. Among our people in the United States, the demand for doctors' services has been greatly stepped up.

Mr. HÉBERT. There is no indication—

Secretary PATTERSON. And the earnings available to them have also been greatly increased.

Mr. HÉBERT. Well, there is no indication at all that that acceleration will slow down to any appreciable extent. Instead of slowing down, it will probably be accelerated, if we continue our way of thinking.

Secretary PATTERSON. Take the difference between doctors and lawyers. The output of the medical schools of this country is 5,000 per year. That is all.

Mr. HÉBERT. Of doctors?

Secretary PATTERSON. And they can't expand quickly. It takes too much in the way of money, endowments, hospital connections, and all that thing. Now, contrast it with lawyers. You and I could go down and open a law school tonight, by hiring a room, and get some students. You could have the thing go right along fast. The output can be quickly adjusted to any need you have, or supposed need. That is not true in medicine. All you have is that 5,000 per annum output, year after year, and no prospect of any considerable increase.

Mr. HÉBERT. Well, that—

Secretary PATTERSON. That is the capacity.

Mr. HÉBERT. That emphasizes my point, Mr. Secretary, that we have to recognize the attraction for the medical man on the outside, in civilian life. There is no indication that this capacity is going to be increased in the near future.

Secretary PATTERSON. Those attractions will not quickly result in a big flow of prospective doctors. It won't do it.

Mr. HÉBERT. That is correct. Therefore, I return to my original suggestion—

Secretary PATTERSON. It is different from law, engineering, and other professions and occupations, in that way, that the supply will be limited for years to come.

Mr. HÉBERT. I agree with you there. Therefore, it becomes more desirable that the Army and the Navy establish their own school to attract the young man who would like to be a doctor and is perfectly willing to exchange his talents for the education by the Government.

Now, General Bliss, in answer to Mr. Gavin's question indicated that from \$10,000 to \$15,000 has been invested in an individual and yet the Government only gets 2 years' service out of him at the most under the present program.

Secretary Patterson. That is right.

Mr. HÉBERT. So wouldn't it be more practical, more economical, and more desirable to let the armed services set up this school for the individual who wants to go into the school and become a doctor, being willing to exchange his talents over a longer period of years, so that the Government could get its investment back? In that way they could also train these individuals in the particular fields which are peculiar to the armed services, such as gunshot wounds, tropical diseases, and all that goes with the sides of medicine which are peculiar to the military field. Don't you think it is perfectly logical approach to it?

Secretary PATTERSON. It is an interesting speculation. I just don't know enough to comment adequately on it. I have no doubt that it has been thought of.

Mr. HÉBERT. But you would not oppose such a policy?

Secretary PATTERSON. No.

Mr. HÉBERT. Do you think it logical at this time to make a survey of that proposition?

Secretary PATTERSON. Yes, I do.

Mr. HÉBERT. That is all.

Secretary PATTERSON. I am told that Dr. Churchill will be in a position here to touch on that topic.

Mr. BLACKNEY. Mr. Norblad?

Mr. NORBLAD. No questions.

Mr. COLE. Mr. Chairman.

Mr. BLACKNEY. Mr. Cole.

Mr. COLE. May I ask one question of the Secretary?

Mr. BLACKNEY. Yes.

Mr. COLE. Would there be any serious objection to having this program run for a 5-year period? By that, I mean, after 5 years that no new men taken into the Department will get the bonus. Of course, those who have joined between now and 5 years from now will continue. There will at least be a semicontractual obligation on the part of the Government to carry it on for the rest of their career.

Secretary PATTERSON. I see no advantage in putting in such a limitation, Mr. Cole. When I went over to the Bureau of the Budget with this bill such a provision was impressed upon me by the Director of the Budget. I resisted it, and said, "Why wave a red light in people's faces? This is a party for drumming up recruits. You got to get people in. That is the whole purpose of the bill. Why tell them, right on the face of it that after 5 years this will all stop?"

You can change it in 5 years without reserving any right in the bill to do so, anyway. All pay is subject to the pleasure of Congress.

Mr. COLE. I don't propose stopping the pay at the end of 5 years for those who have joined between the adoption of this bill and the expiration of 5 years. I don't mean that. However, it seems to me—

Secretary PATTERSON. The Bureau of the Budget's idea was to just place a 5-year limit on, say, the \$100 a month extra pay.

Mr. COLE. I think your thought on that is sound, but it does seem to me that if a provision were inserted, that this available bonus would continue only for 5 years, instead of being a red light it would be a green light to the medical people.

Secretary PATTERSON. That is possible.

Mr. COLE. If they want to get on this, they better start now.

Secretary PATTERSON. That is possible.

Mr. COLE. But if they want to take a try at it in civilian life, taking a chance on it and perhaps failing, and then expect to come back into the Army, with this program being used as a last resort for the medical people, it seems to me if some periodic limitation were placed on it, it would be an inducement for them to join up now if they expect to get it, whatever inducement there is in this \$100 increase.

Secretary PATTERSON. I don't think I would have any serious objection to that kind of a provision, as you sketch it. It may have a valuable thought in it.

Mr. COLE. That is all, Mr. Chairman.

Mr. BLACKNEY. One question, Mr. Secretary. What will be our potential peacetime Army?

Secretary PATTERSON. I can't say. As long as we have occupation in Germany and Japan, I believe it will be close to 1,000,000 men. I have seen studies in the War Department for a theoretical post-occupation Army, as they call it, where they have it at I think around 800,000 men. When I ask, "When is that time", they say, "Oh, I can't say about that."

It seems to me rather visionary to try to estimate what our requirements will be at that distant period. I think we can take it that the

period of occupation will be of indefinite duration. I can't say. As long as we have the problems of occupation, we will have a need I believe for close to 1,000,000 men.

Mr. BLACKNEY. My only purpose in asking that, Mr. Secretary, was to determine the numerical strength of the Medical Corps.

Secretary PATTERSON. About 6,000 officers.

Mr. BLACKNEY. About what?

Secretary PATTERSON. About 6,000 medical officers.

Mr. BLACKNEY. Well, that would be on the basis of 1,000,000 men in the service, you mean?

Secretary PATTERSON. Yes, sir.

Mr. BLACKNEY. Any other questions?

Mr. GAVIN. I can't understand why we have had only 218 applications out of the 9,000 we trained and educated. With other branches of the service there seems to be a devotion to the service. What happened that out of that large group only 218 elected to continue in the service? I can't understand that.

Secretary PATTERSON. That, Mr. Gavin, is a fact. The attractions of a civilian career in medicine are more alluring than a career in Army medicine, on present pay and—

Mr. GAVIN. Possibly General Bliss can tell us what the average income of the physician in civilian life is.

General BLISS. We have some charts here which will show that. The average income now of a young man starting out as a general practitioner is \$7,800 a year.

Mr. NORBLAD. That is the starting income?

General BLISS. That is the starting income. There are instances at the present time in the State of Connecticut, for example, where they are trying to get men just out of school, with a year's internship, with an offer of \$750 a month and cannot get them. That exists now in the medical profession outside.

Mr. GAVIN. At the same time, we have branches of the Federal service where we are seeking applications from qualified engineers, statisticians, economists, and other specialists, for the civil service at \$8,000 or \$9,000 a year. Why do those men stay in the service and not go out and pick up these other assignments? They are not paid proportionately.

General BLISS. Every Army officer, after 10 or 15 years in the service, of course, gets an equity in the service and it is very hard for him to get out then. Most of our men who have resigned have been the men who have come in since 1940, the young men who came in then. Very few of our older men, after that time, feel that they can leave, although they all have opportunities.

There is an opportunity for every man in the Regular Army Medical Corps to leave now at a very substantial increase in the salary that he is getting now. You do develop a certain loyalty to the service, naturally. It is a very intense loyalty that you develop, but after a certain number of years you want to go. You may not be dissatisfied, but you want to go. We are losing the younger men who came in since 1940. There are not very many of those who came in at that time. Also we are losing by attrition the men who came in during the last war. All of our top grade officers are going out now because they have reached the age limit to go out. They are allowed to retire after 30 years' service.

Secretary PATTISON. You don't mean the last war. You mean World War I.

General BLISS. World War I, yes, sir.

Mr. PATTISON. I am told that the Federal Government in other branches, the State governments, and county governments—with all of their regulatory bodies and services rendered—are having the same trouble: shortage of doctors. That goes especially for the State hospitals.

Mr. GAVIN. Are our educational institutions doing anything about it?

Secretary PATTISON. They all have their regular output—as I say, 5,000 per year.

Mr. BLACKNEY. Mr. Secretary, in view of the attractive salaries that physicians can get in civilian life, is \$1,200 a year going to be inducement enough to retain the Medical Corps that you desire?

Secretary PATTISON. I am sure it is an inducement. I can't measure the force of it, but it will have some force. We believe, however, that the other features of the bill will have a pulling power as well. The members of the Medical Advisory Committee impressed upon me the fact that you had to offer an attractive career in the Army to doctors as a profession. That was why they wanted these four professorships and urged strongly that that be taken on.

Now, as to the other features of the bill, such as recruitment from civilian life and the specialist pay—they say it is not purely a question of emoluments. They want to have a high standard of medical care in the Army and Navy. That will attract them. They want to get, for example, the medical schools impressed with the advantages of medicine in the Army and Navy and what they offer a man for a proficiency in his profession.

Mr. BLACKNEY. Assuming that all five titles of the Army bill remain, could you tell me the estimated cost of the measure?

Secretary PATTISON. No; I could not.

Mr. BLACKNEY. We will get that later?

Secretary PATTISON. Yes; that will come.

Mr. BLACKNEY. Thank you very much, Mr. Secretary.

Secretary PATTISON. Thank you, sir.

Mr. BLACKNEY. We will call the Secretary of the Navy, Mr. Forrestal.

Secretary FORRESTAL. Good morning, Mr. Chairman and gentlemen.

Mr. BLACKNEY. Have you a statement, Mr. Secretary?

Secretary FORRESTAL. Yes.

#### **STATEMENT OF JAMES FORRESTAL, SECRETARY OF THE NAVY**

Secretary FORRESTAL. I suspect a good deal of it repeats what Judge Patterson has already said. I have made mine, for that reason, fairly brief, and I may omit parts of it.

I may say at the beginning—this is something which the members of your committee all realize—if we are to keep abreast of developments in medicine and surgery and preserve a spirit in the Medical Corps which makes it quickly adaptable to war, it is most essential that we keep a good, sound Medical Corps in both the Army and Navy, because this Nation places possibly a higher premium upon individual life and insists in wartime upon a greater care for its

fighting men than practically any other Nation except the British. For that reason you can't create that preparation overnight. It is something that has to be a matter of continuous growth, continuous care and attention, to see to it that we have the fundamental, sound medical people in the services that can keep it alert, aware, and modern during peace; capable of swift expansion in war.

This bill that you are considering was submitted, I believe, to the Congress by both the War and Navy Departments. Its purpose is to provide additional inducements to attract physicians and surgeons to a career in the Medical Corps of the Army and Navy and to curtail the alarmingly large number of resignations, that you have heard about from the Secretary of War.

On the 15th of August 1945, there were 1,949 medical officers in the Regular naval service. Since then there have been 864 applications submitted for resignation from the naval service. Procurement efforts have not been effective, because of our inability to compete with inducements offered by opportunities in civilian medicine. Two-hundred and seventeen medical officers have been obtained for the Regular Navy since August of 1945, in spite of the fact that a high percentage of the 12,000 Reserve officers on active duty were eligible for transfer.

On the 21st of April of this year there were 1,672 regular naval medical officers on active duty. That number will be reduced on the first of next month to 1,244, because of resignations and retirements. The Medical Corps of the Navy for the next few months will be able to function reasonably well, because, as in the case of the Army, there are still on duty over 2,000 Reserve medical officers. Of that total of 2,051, only 176 are being retained on active duty at their own volition and 70 of these have already requested release by the first of next month. The remaining 1,875, who are graduates of the Navy V-12 program, are being held on active service involuntarily, and I may say I have a very substantial number of requests, as undoubtedly you gentlemen have, from individuals who desire to accelerate their release. They will all be eligible for separation from active duty upon the completion of the 2 years of obligated service, which, generally speaking, is a very close date ahead.

Admiral SWANSON. Yes, sir.

Secretary FORRESTAL. When all of these Reserve medical officers are released, we shall have approximately 1,050 medical officers remaining in the Regular Navy. We shall be short 1,950, or a shortage of about 65 percent of our requirements.

From these figures, it is clear that we are able to function today only because of the use of the Government subsidized V-12 Reserve officers. By the 1st of July 1949, the situation, I think it is no overstatement to say, will be critical, unless we can change the direction and the rate of flow in and out of the Regular corps.

The pay of the medical officers of the armed services is at present below the scales available in the Veterans' Administration and substantially below the scales available in civilian practice.

This bill has three essential features. Title I provides for the \$100 per month additional pay for all medical officers on active duty in the Navy. The total amount to be paid under this title to any one officer during this entire lifetime of service is limited to \$36,000.

Title II provides the authority to designate specialists who are certified by an American medical specialty board and recognized by the Surgeon General to receive an additional 25 percent of their base and longevity pay while on active duty. This inducement is similar to that already available to the Veterans' Administration medical people. These specialists, I might say, are doctors who have spent relatively long periods of time in becoming experts in various fields and whose proficiency in those fields has been recognized by one of the American medical speciality boards which pass upon such matters.

Title III gives the President the authority to appoint recognized specialists in the Medical Corps of the Navy in commissioned grades not above that of captain. Such physicians and surgeons are to be carried as additional numbers in grade, but shall not increase the authorized number of commissioned medical officers of the Regular service. Stated in other language, Doctor Swanson, that means that you are not limited by age qualifications in the selection of men for this particular billet of specialist?

Admiral SWANSON. That is correct, sir.

Secretary FORRESTAL. The estimated cost of this bill for the fiscal year 1948, with an average on-board strength of 3,096 medical officers, will be \$3,715,000 to implement title I and \$37,400 to implement title II, provided this bill becomes law.

The increases in pay proposed will not apply in computing either retired pay or longevity increases. The problem of procurement of medical officers for the armed services is becoming more difficult and is now critical. Many plans have been studied, but this plan is believed to be the most promising solution. It can be implemented quickly. It should be effective immediately. It will attract medical officers to the service as well as serve to retain those that we now have.

The basic concept of the bill proposes to reimburse the medical officer for the excessive expense and time required to prepare for a service medical career, as compared with the initial requirements for the career of a general officer.

I believe that the methods employed in the computation of the amounts of the proposed pay increase are fair and just. I subscribe to this principle, and I particularly endorse title I of this bill which provides for the \$100 per month additional pay for all medical officers on active duty in the armed services.

Mr. BLACKNEY. Let me ask you, Mr. Secretary, with reference to the Navy, the same question I asked with reference to the Army. What will be the potential peacetime strength of the Navy?

Secretary FORRESTAL. That will have to be and should be governed by the conditions of the world, and when, as, and if we have treaties of peace written, we have a United Nations that is functioning, the Navy can be very sharply reduced, but until that time I hope this Congress doesn't put any drastic knife into the Navy.

Mr. BLACKNEY. My only purpose in asking that question is to determine the relation between total personnel and your medical corps. What is the ratio between the number of men in the naval service and a corresponding adequate medical corps?

Secretary FORRESTAL. In other words, the proportion of say a doctor per number of men. It is about 1 to 10 officers, isn't it, Doctor?

Admiral SWANSON. Six and a half per thousand.

Secretary FORRESTAL. Six and a half per thousand. That is the ratio, six and a half medical officers per thousand of personnel.

In civilian life it is what, Doctor?

Admiral SWANSON. The ideal is 1 doctor to 700 people. Actually, in the Navy, we had 1 doctor during the war to 630 people, that we actually take care of.

Mr. COLE. What is it in civil life?

Admiral SWANSON. About 1 to 750.

Mr. COLE. I am not speaking about the ideal. I am talking about the actual.

Admiral SWANSON. For the large cities it is about 1 to 700.

Mr. BLACKNEY. Why is this bill limited to a 5-year period?

Admiral SWANSON. The Bureau of the Budget thought that that would be well, so it would allow the Members of the Congress to look into the advisability of this bill after a 5-year period.

Secretary FORRESTAL. I share, I must confess, in some of Judge Patterson's remarks on that. I think it is, of course, the inherent prerogative of Congress to make adjustments any time in rates of pay. I do not regard its inclusion or exclusion as a matter of substance.

Mr. BLACKNEY. Does this bill include reserves on active duty, should this bill be passed?

Admiral SWANSON. Yes, sir.

Mr. BLACKNEY. Just one question, simple in its nature: Why does one bill provide \$100 a month and the other \$1,200 a year? It is the same, but was there any purpose underlying it?

Secretary FORRESTAL. I don't think so. I imagine it just happened to be mentioned that way. They should be brought into harmony.

Mr. BLACKNEY. All right. Why does the Navy include doctors now on active duty who have had more than 30 years' commissioned service?

Admiral SWANSON. We have a great many doctors who during this calendar year will have had 30 years' service. We want to retain the maturity and the good medical judgment that these doctors have, to offset all the young doctors. We feel, if they are not included in this, they will choose to retire after 30 years, and I for one want to retain these doctors beyond the 30-year period.

Mr. BLACKNEY. Has the Navy at any time entertained the thought of a medical school for the service?

Secretary FORRESTAL. Not to my knowledge, but Dr. Swanson may be able to answer.

Admiral SWANSON. We have postgraduate medical schools for the various specialties, but we have never entertained the thought of educating M. D.'s. We think we ought to use the existing facilities of this country. At the present time there are 70 accredited A schools. When I come up to testify, I will be very glad to amplify on this thing. I have plans that I am working on now with Dr. Bortz, the president-elect of the American Medical Association, in which we can improve the whole standards of American medicine.

Mr. GAVIN. May I ask a question at that point?

Mr. BLACKNEY. Just a minute. Would the doctors under the V-12 program be eligible for this increase?

Admiral SWANSON. Yes, sir; if they agree to remain an extra year.

Mr. BLACKNEY. Mr. Gavin, did you have a question?

Mr. GAVIN. I quite agree that this increase is necessary to interest these men to remain in the service. However, I can't believe that it is the solution to this problem. If we are turning out 5,000 graduates in the medical profession each year and are going to attract certain ones into the Medical Corps of the service, then we are going to take them away from civilian life. I am trying to ascertain how we can increase the number in the medical profession to meet both the demands of our civilian life and the Army and Navy demand. That is a question I think we should be discussing: How we are going to develop a program to increase the number entering the medical profession, making it attractive enough for them? I think that the Congressman's point is well taken: that some thought must be given to the establishment of preparatory institutions to educate our youth for service both in the Army and Navy, unless the outside educational institutions are going to accelerate their programs to develop these young men.

Admiral SWANSON. The physical capacity of medical schools is now saturated. For instance, at George Washington University Medical School in this city, they have had 1,500 applications. The physical capacity only permits 80 students for the freshman year. There is a normal attrition during that 4-year period, due to various reasons, of 25 percent, so they will graduate 60. Therefore, the medical school physical plant of this country must be increased to take care of the increase in the population.

Secretary FORRESTAL. I suspect also, Mr. Gavin—it may be somewhat irrelevant—that the concentration of population, which has removed the old country practitioner and has correspondingly increased specialization in medicine, has affected the situation. In my town there were three or four doctors, and they did everything from gynecology to tonsillectomies and appendectomies.

Mr. GAVIN. Even small towns find it difficult now to get a medical man to go into their community.

Secretary FORRESTAL. Yes; that is one of our great problems.

Mr. GAVIN. Because it is not attractive enough.

Secretary FORRESTAL. It is not only the small income in those communities, but it is the lack of facilities, Mr. Gavin.

Mr. GAVIN. That is right. In many cases the nearest facility is 15 or 20 miles away.

Secretary FORRESTAL. Yes.

Mr. GAVIN. I can't see why we shouldn't be giving some thought, both in the Army and Navy, to taking advantage of facilities that are already established, so as to coordinate our program. Mention was made of one university that had 1,500 applications and is set up to accept some 80 applicants. We should be directing our attention as to how the Government can step into this situation and be of assistance to those institutions, so as to extend their programs and facilities to accept more students.

Secretary FORRESTAL. I think, Mr. Gavin, as a matter of fact the President, and, I think, Members of the Congress, have directed their attention to that problem. It is a national problem; there is no question about it.

Mr. BLACKNEY. Mr. Cole.

Mr. COLE. You said that this \$100 bonus would become available to Reservists on active duty, but isn't it necessary for them to agree to

stay in the service for an additional period, a definite period, in order to be eligible?

Secretary FORRESTAL. I don't think so, Mr. Cole. I think it might be a provision to consider.

Mr. COLE. Just so we can understand—

Secretary FORRESTAL. I am informed, under our bill, the V-12 will be eligible for that increase if they remain an additional year.

Mr. COLE. After their 2 years of obligated service.

Secretary FORRESTAL. That is correct.

Mr. COLE. Doesn't that same year of required service apply to a reservist who is on active duty, in order to be eligible to draw the \$100 bonus?

Admiral SWANSON. No, the reservist gets it at once, when he is on active duty.

Secretary FORRESTAL. There is this distinction: The reservist presumably has not had the benefit of the Government funds to obtain his education.

Mr. COLE. Why do you require a year of extra duty of the V-12 doctors and don't require it in order to draw the bonus?

Secretary FORRESTAL. I would say that he already has received substantial benefits. We do need a certain stability, for planning purposes, as to what we have in terms of medical people in the Navy.

Mr. COLE. By virtue of his 2 years of obligated service he has paid off his obligation for those benefits—theoretically anyway.

Secretary FORRESTAL. I wouldn't think so, myself. I think these young men have had—I don't mean to make any aspersions on them at all—very great advantages during the war.

Mr. COLE. No question about that; but at the same time when the advantages were given to them the obligation was to serve for 2 years; wasn't it? Or at least that was my understanding.

Secretary FORRESTAL. Remember, this was designed as an incentive to meet an immediate situation. I do not believe the full purpose of that incentive for which it is given would be served if you have to face instability and uncertainty. Dr. Swanson may want to comment on that. I would think, for the purposes of planning, you would be in a most unsatisfactory position if you didn't know precisely how many people you could count on. Have you any other observation to make on that?

Admiral SWANSON. Well, the Government has already educated the V-12 doctors, whereas the reservists that are now on duty have educated themselves at their own expense, so we felt that they should not get the extra pay until after 1 year. It would also be an incentive for them to join the regular service. If they join the regular service, they will get it at once.

Mr. COLE. Is it possible in the Navy to commission a person for a minimum period of time?

Secretary FORRESTAL. To limit the length of his commission?

Mr. COLE. Not a maximum, but to require a minimum period of service.

Secretary FORRESTAL. That does not exist in law, I believe, now. Captain Nunn, do you know that? I think we have no power, that I am aware of, in that respect.

Mr. COLE. The thought that prompted my question—

Secretary FORRESTAL. Captain Nunn, is there any power in the existing organic law which would give me the right to limit the term of service for commission?

Captain NUNN. No, sir.

Mr. COLE. Well, the thought that prompts the question is whether it might be advisable to require of these officers who are to get this extra emolument a minimum period of service in order for them to qualify.

Secretary FORRESTAL. I think if that additional pay were more substantial, Mr. Cole, there might be something in that, but, after all, this extra amount is not, in terms of present comparisons, a very great one.

Mr. COLE. I agree with you. Let me inquire of the Navy about the dental situation.

Secretary FORRESTAL. I had the same thought that you raised, and I think we should look into it. The fact is that it is not in as critical a condition as that of the medical officers. Of course, there is the further fact that the dental people do not have to go through so long a period of education. Their average, I think, is 6½ years. On the other hand, I have raised that question already with Dr. Swanson. I propose to look into it.

Mr. COLE. What thought has the Navy given to the use of contract physicians?

Secretary FORRESTAL. What—

Mr. COLE. Obtaining medical services through contract of local physicians, rather than from your staff.

Secretary FORRESTAL. We used to do that, you know, and it was not satisfactory. It resulted in some pretty rugged characters, that I personally wouldn't like to expose my limbs, teeth, or other things to. I mean, it was abandoned about—when? Twenty years ago?

Admiral SWANSON. During the last war.

Mr. COLE. It was abandoned when?

Secretary FORRESTAL. It was before the last war, I think that it ceased to be a practice. We have given consideration to that, as a matter of fact, in looking at this problem—

Mr. COLE. But you rejected it, apparently, because it isn't in the bill?

Mr. COLE. Can you tell me why you rejected it? I can't believe you rejected it because of your experience two or three decades ago, where a few obnoxious people were hired, because if they were hired that was the fault of the Navy.

It seems to me, at least in theory—perhaps it doesn't work out in practice as being advisable—to be a good plan where you have established Navy activities and Navy hospitals in communities that have sufficient doctors, to have them come in periodically and help you, so as to relieve your current load.

Admiral SWANSON. At the present time we have in our hospitals consultants. These consultants are the finest doctors in all the towns where our hospitals are located. They give unstintingly of their time, on a consulting basis. We have the advantages of the cream of the medical profession in the towns where we have our hospitals even at the present time, but—

Mr. COLE. Then you are currently following the practice of contracting with physicians?

Admiral SWANSON. Yes, sir; on a consultant basis.

Secretary FORRESTAL. Do you pay them, Dr. Swanson?

Admiral SWANSON. Yes, sir; we pay some. Some of them do not accept the pay, but we do pay them.

Mr. COLE. They are purely on a consultation basis. They don't do any operating?

Admiral SWANSON. Yes, sir. For instance, we have the professor of neurosurgery at the University of Virginia, who comes up to the Naval Hospital at Bethesda and frequently does brain surgery.

Mr. COLE. That is on contract?

Admiral SWANSON. Any of the consultants can do any surgery they wish in their own field.

Mr. COLE. Then you are practicing the system—

Secretary FORRESTAL. I wouldn't say it was a system, Mr. Cole. I mean, it isn't designed to accomplish the end purposes that this bill is proposed to meet.

Mr. COLE. No. My thought was, if you didn't take advantage of available medical talent in localities where you have a deficiency of your own medical personnel, I thought you should do it.

Admiral SWANSON. We use these consultants primarily from an educational standpoint, to educate the young doctors.

Mr. COLE. How about this idea of four professorships that the Army bill provides? Has the Navy given any thought to the advisability of that?

Admiral SWANSON. I think that is a feature that we could well take from the Army—the four consultants—because we could use them in our training program. I think that title would add materially to our bill.

Mr. COLE. How would you use them? You are already getting—

Admiral SWANSON. We have a training program.

Mr. COLE. Specialist talent in your training program.

Admiral SWANSON. Yes.

Mr. COLE. How would you use these four superprofessors?

Admiral SWANSON. They would go around to the various hospitals to see that the training program which is now in vogue is up to proper standards. They would be used more or less as inspectors of training.

Secretary FORRESTAL. I had Dr. McLean, of the Strong Memorial Hospital at Rochester, 2 years ago, head a board to make a study for me of the whole medical problem. His group came out with the conclusion that one of the things we needed to do to attract and hold the good young men was to give them the confidence that they would have access to internships in good hospitals and access to progress in their profession, in terms of exposure to lectures and the continued education of the leaders in the profession. In addition to pay, that is one of the strongest incentives we can offer.

Mr. COLE. But you are doing that now?

Secretary FORRESTAL. Well, I mention it in passing because it is a consideration which is important, in addition to the money.

Mr. COLE. One other question. Do you see any objection to inserting a provision that this bonus should not be available to anybody who joins up after 1950, or 1951?

Secretary FORRESTAL. It doesn't strike me as being important one way or the other. I should like to reserve the privilege of looking at

it and talking a little bit with Dr. Swanson on it, and then making my response to that later.

Mr. COLE. That is all.

Mr. BLACKNEY. Mr. Hébert.

Mr. HÉBERT. Mr. Secretary, pursuing further Mr. Cole's question in connection with the dentists, you do think the dentists probably have a valid reason to approach this problem in the same manner that the doctors do?

Secretary FORRESTAL. I think, if an impression got out that they were being discriminated against, I should regard that as unfortunate, but the critical part of this problem that has been forced upon our attention has been that of the medical officers themselves. I propose to go into that question with Dr. Swanson. There is a difference in the investment of time and capital of the young man who goes into the dental profession as compared with the young man that goes into medicine, a difference of about two and a half years—

Mr. HÉBERT. Well, anticipating a future condition arising in connection with the dentists, do you not think it would be the policy of wisdom to also consider it at this time? In other words, don't let us be confronted with the situation when it becomes critical. Rather, let us anticipate it.

Secretary FORRESTAL. I think it would be good sense.

Mr. HÉBERT. To anticipate it at this time?

Secretary FORRESTAL. Yes.

Mr. HÉBERT. Now, when I made the suggestion to the Secretary of War you were present in the room and you heard his response to my inquiries. What is your reaction to the thought of establishing a medical school for the armed services, so as to educate their own doctors?

Secretary FORRESTAL. I think it is an interesting and provocative suggestion. I think it should have the study of not only our own people, but others in the profession competent to pass upon it, taking into account, I think, limitations not merely of equipment in the medical profession, but also the limitations of teachers. I would doubt that right now you could get the kind of competence in a staff of teachers in such a medical school that you would want, to turn out the people that you would be happy to have. It is worth studying.

Of course, the matter of medical care of the rural areas that has been discussed with Mr. Gavin, together with the shift in our population, all of which have occurred in the last generation, I think do indicate a very thorough study of the whole problem of medical attention and care in this country is needed. I know it is one of the paramount things in the mind of the President.

Mr. HÉBERT. I think we would agree, for the future, instead of this situation clearing up it is going to be exaggerated. It will spread out even more. I want to make particular reference to what Admiral Swanson said, that we have 70 accredited "A" schools in this country who turn out 5,000 graduates a year. He gave us one indication of a school, and that was George Washington, which had 1,500 applications and only physical facilities to accept 80 new students.

Now, thousands and thousands and thousands of young men in this country—in contrast to the individuals I indicated who did not have the financial stability or background to enter a medical school—today

are being turned away because there are not the physical facilities to be found. Then, in connection with the President's health program, these facilities are going to be even more in demand, as we expand our health program. Doesn't it become more necessary that we look forward, with a long-range view, to establishing that school for the armed services, where we will have these facilities and the individual who does want to study medicine can be given that opportunity?

Secretary FORRESTAL. I would say that your suggestion is part of the whole problem. It ought to be studied by us in conjunction, however, with the pattern of Federal action, whatever it may be, that is laid down.

Mr. HÉBERT. Well, of course, I don't think the two should be confused, and I don't think you want to leave the impression that they should be confused. This is a peculiar situation and it addresses itself directly to the armed services, such as gunshot wounds, as I suggested before, and these tropical diseases. Our armed forces are going to be all over the world from now on. They are not going to be confined to this country. Don't you think the logical policy is for us to go into this problem seriously? Of course, I realize this can't be done tomorrow, next week, or next year. It is a long-range program. But we have to recognize the problems that are going to confront us in the future, from knowledge of the facts that we have at hand at this time.

Secretary FORRESTAL. I would agree that it is something that we should give serious study to.

Mr. HÉBERT. And you would agree to a direct study being made as to the advisability and feasibility of setting up our own medical school for the armed services?

Secretary FORRESTAL. Yes. I just don't want to respond too casually to a question on a subject that is outside of my own special capacity to judge, without that kind of a study. I wouldn't want to either express approval or disapproval without going into it fairly exhaustively. I think it is a provocative idea, and I think it is a good idea to explore.

Mr. HÉBERT. Naturally, I don't expect you, any more than you would expect us here, to commit yourself on a problem that you are not fully cognizant of. At least I want you, as Secretary of the Navy, to express an affirmative interest in exploring that field.

Secretary FORRESTAL. I so do.

Mr. HÉBERT. That is all.

Mr. BLACKNEY. Mr. Norblad?

Mr. NORBLAD. No questions.

Mr. BLACKNEY. Mr. Blandford, do you have any questions?

Mr. BLANDFORD. I want to ask Admiral Swanson a question of interpretation on title I. In the third group, the bill states that "those commissioned officers of the Medical Corps of the Naval Reserve who are on active duty on the effective date of this amendment." Then, in the fourth group, you state that, "Such officers, now or hereafter commissioned in the Medical Corps of the Naval Reserve, as may, during the 5-year period immediately following the effective date of this amendment, volunteer for extended active duty of 1 year or longer."

That goes back to the question as to whether V-12 students who still have 2 years to serve, or a year, or 18 months, whatever their

contract calls for, will, under your bill, receive the \$100 increase immediately. Aren't they Reserve officers on active duty?

Admiral SWANSON. Yes; they are Reserve officers on active duty, that is right.

Mr. BLANDFORD. Wouldn't something have to be done to your bill to prevent them from getting the \$100 increase?

Admiral SWANSON. Yes, sir.

Mr. BLANDFORD. I believe Captain Nunn might be able to answer that question.

Captain NUNN. The answer is yes, something would have to be done in the bill to prevent their receiving the additional \$100. The Army and Navy drafts are different in that respect.

Mr. BLANDFORD. What is the thought of the Department now on the question as to whether the V-12's should or should not be eligible for this \$100 increase, provided that they still have some time to run on their own contract?

Admiral SWANSON. I think they should be included if they volunteer for an additional year of duty.

Mr. BLANDFORD. Should they be entitled to receive it immediately, provided that they will as of the enactment date agree to extend their service for an additional year before their contract date?

Admiral SWANSON. Yes; if they agree to extend 1 year, they should be included.

Mr. BLANDFORD. If they do not agree to extend, and they still have some time to run on their contract, should they then be precluded?

Admiral SWANSON. I would say No to that, but they could be included by requesting a commission in the Regular Navy.

Mr. GAVIN. Mr. Chairman.

Mr. BLACKNEY. Mr. Gavin.

Mr. GAVIN. I think the admiral has brought out a very excellent point here today, in using George Washington University as an illustration. It is evident that there is not a lack of desire or ambition on the part of the American youth to enter the medical profession, but it is a lack of planning on our part to provide the facilities to give him that education. I think the Congressman's suggestion is an excellent one. That should be a very important matter to consider in this legislation.

Mr. BLANDFORD. Admiral, an additional question on title III. Does not the Navy have the power at present to make original appointments to the Medical Corps of the Navy?

Admiral SWANSON. Yes, sir; they do have the power.

Mr. BLANDFORD. How does Title III change the existing law?

Admiral SWANSON. In title III, we take medical and surgical specialists. Under present law we are allowed to take a doctor into the regular service only up to the age of 32. If this title III be enacted, we can then take a specialist certified by one of the American specialty boards into the Navy at an age group higher than 33.

Secretary FORRESTAL. It gets away from the present limitations on age in grade. In other words, if you want to take a man of 45 and make him a lieutenant commander, the present law wouldn't permit you to do that. He would have to either qualify in the higher rank or you wouldn't take him at all. This permits you greater flexibility on the matter of age.

I am interested in that because I have seen a number of Reserve officers—I say a number, at least a half dozen men over 55 that were competent doctors. Under our existing practice, we did not take them because their length of time ahead of them to serve was so short.

Mr. BLANFORD. One additional question for the sake of the record. This \$100 increase will not be included in determining longevity pay, is that correct?

Secretary FORRESTAL. That is right.

Admiral SWANSON. Yes, sir.

Mr. BLANFORD. That is all.

Mr. BLACKNEY. I think that concludes the questions. We thank you for your statement.

Admiral SWANSON. Thank you, sir.

Secretary FORRESTAL. Thank you, gentlemen.

Mr. BLACKNEY. General Kirk.

General KIRK. Mr. Chairman—

Mr. BLACKNEY. Have you a statement?

General LIRK. I do not have a prepared statement, sir.

#### **STATEMENT OF NORMAN T. KIRK, SURGEON GENERAL, WAR DEPARTMENT.**

General KIRK. I am very much interested in this legislation. We have been studying legislation, knowing the situation that the Medical Department is going to be in, for the last 2 years. The Navy, fortunately, was able to increase their medical corps during the war. The Army wasn't.

This legislation is vital, if we are to have an Army. We must have a medical service for that army. At the present time there are 1,100 Regular medical officers.

Mr. GAVIN. How many?

General KIRK. 1,100. Within a year, there will be some more that will retire and more will resign, I am sure. That is enough Medical Corps officers to give service to about 200,000 enlisted men. As the Secretary has told you, it looks as if we are going to have a 1,070,000-man Army for a period of some time to come. Whether it is 1,000,000 or 850,000, there are enough Regular medical officers to give service to a 200,000-man Army, and that is all.

We have attempted during integration to bring officers into the corps, without success.

This bill has been brought out, as the Secretary has told you, not only by the Medical Department, but started and was abetted by the civilian consultants who served with us during the war. They were leading men in American medicine, being the leading professors in medical schools today, that advised the Secretary in helping write this bill.

Now, there are various segments to the bill. I might take them up one by one.

Extra pay: The Army's plan was that we pay the officer \$100 a month or \$1,200 a year for the first 30 years' service. This was simply a procurement idea. We actually had difficulty getting this bill through the War Department. They felt no officer should re-

ceive any more pay than any other officer. But we were in a competitive market. We must have doctors.

Now let us look at the pay. All medical officers' pay since 1908 has been increased by 30 percent. Under the present pay bill, the sergeant major—an enlisted man of the Army—with 12 years' service gets the same pay that we pay a doctor who comes in the Army, a man that has gone to school and spent many thousands of dollars for his education. He has had 7, 8, or 9 years of study in his profession, and then we pay him the same as we pay a sergeant major of 12 years' service. He can't live on it. Frankly, he is foolish to do it because, as has been pointed out, the young graduate of medicine today, with a limited internship, can go out and get a job paying \$500 a month or better.

If I might go into a personal experience, I will go back to my experience after the last war, when I was a lieutenant colonel, temporary, doing surgery at Walter Reed, in addition to another general hospital. The operative work that I did, on a lieutenant colonel's pay, cost the Government \$7.50 for each major operation I performed that year. The operations I did was a third of my work.

During the war we had these wonderful men from American medicine, outstanding men that left their families and went into the war, who made it possible for us to come up with this wonderful record. Our Army was way ahead of any other. It was those people who volunteered that made that possible. They didn't get compensation anywhere near what they should have had.

Now we must make it attractive to the young doctor, if he is going to come into the medical service. We think he ought to have enough money to live on, to feed his wife and children. He isn't getting it now. This \$100 a month will increase the pay of the lieutenant, the grade with which he comes into the service, 50 percent. This will increase the colonel's pay 19 percent. That is the increase in pay that this will give.

Then these youngsters are interested in something more than pay. If you go through these medical schools, you will understand that every boy wants to take residency training and become a specialist.

Mr. COLE. General, will you put that percentage for each grade in the record?

General KIRK. Fifty percent for the lieutenant. It amounts to 19 percent for the colonel.

Mr. COLE. What is it for the captain?

General KIRK. That is on his base pay.

Mr. COLE. What is the percentage of increase for a captain?

General KIRK. I have it right here.

Mr. COLE. Put it in the record.

General KIRK. It amounts to an increase in pay for a lieutenant of 50 percent, 41.4 percent for a captain, 30.3 percent for a major, 24 percent for a lieutenant colonel, and 19.5 percent for a colonel.

Mr. COLE. All right.

General KIRK. That is based on his base and longevity pay of grade.

Now, I say in addition to pay and enough to live on, these youngsters are interested in getting residency training and becoming a specialist. That training amounts to from 3 to 5 years. We have

set that up in the Army now, a program to give these men residency training so they can pass the board. The Army and the Navy must be a cross section of American men, I am sure you appreciate.

We have some 300 civilian consultants today who are assisting us in residency training and assisting in patient care in our hospitals here in the United States. That is going on now.

The second provision of the bill authorizes the payment of a 25-percent increase in pay to those men that are designated as specialists and certified by an American specialty board. We have in the Medical Corps today about 100 men, of the 1,100, that have passed the boards and who would be entitled to that additional pay. It will take the average youngster coming in, as we have it planned, some 6 to 8 years before he reaches the perfection of a specialist and we will be able to pay him that additional 25 percent. That much training is necessary, graduate training—not to become an M. D., but graduate training in the Army—to make him a specialist. It will take some years before we get a sufficient number of our men trained in the specialties.

The third provision of the bill provides for the four professorships in medicine, surgery, neuropsychiatry, and preventive medicine, with the professorships to be in the grade of general officer. That was very firmly recommended by this consultant group, that we have these outstanding men to provide the leadership and carry through the residency training that we have set up, saying that it is carried on properly, to the end that we can offer to the youngsters something in the way of graduate training. We are going to have to do that if we are going to attract these young men. That is what they want. We have to do that, in addition to providing enough money for the man to live on. It costs the men to become a specialist. They have to belong to medical societies, which costs them money. I know it has cost me \$80 a year, out of my own pocket, to belong to the medical societies that I belong to, and I belong to some of the best. The Government doesn't compensate me for it. It comes out of the money that I need to raise my family on. They even have to go to the medical meetings, which also costs money. That applies equally to the Navy as it applies to us.

Another provision of the bill permits the Surgeon General to select some specialist that can be brought into the corps over the age of 32 years and commissioned to carry on in some job that we have to do.

Another provision provides for the hiring of people without going to civil service on a contract basis for a definite period. Actually, if we had our full strength of 3,000 which the War Department allows us and we could recruit our medical corps up to 3,000, from 1,100 to 3,000, we would only have 50 percent enough doctors to do a job. We have got to get them somewhere, if we are going to have an Army of 1,000,000. That is why the provision was put in so the Secretary can hire people without going to civil service on a contract basis for a definite period.

Now to come back to the \$100 a month and who gets it. We had written into our bill the man who volunteers for extended Federal active duty for a period of 1 year or longer. We thought that he should volunteer for a year's service before we pay the \$100. We weren't trying to pay out Government money to the officer that came in for a couple of weeks training in the summer. That wasn't it.

It was only to go to the man that we could count on to take the place of the Regular officer, until we recruited a corps. It wasn't our intent to pay it to the ASTP students. However, when his period of service is up and he volunteers for a year's service, we start paying him under this bill \$100 a month extra, over and above his pay. That was our plan. To pay this youngster during the period he is in, I don't think would be fair. It wouldn't be fair to those who went before him and the others that are in now. We have at the present time some 6,700 doctors to give service to our Army; that is our necessity; 1,100 of those are regulars; 600 of them are volunteers. The rest are ASTP students—slave labor they call it because they have the contract and are educated by the Government and they all want to get out. It is from that group that we must recruit these 1,900 doctors we are short. If we don't, there will be no medical service. There are some 2,700 of them being let out in May and June of this year. We are going to be short until some more come in the latter part of the year. Next June, gentlemen, there will be a shortage of 1,500 doctors to give service to the Army strength that we currently have—1,500—and there are no more ASTP's to come in. We are just going to be 1,500 doctors short of requirements, to give medical care to our Army. If we don't get volunteers, or have some schedule on which we can hire doctors—and they are not going to be too good—there won't be any medical service for the Army.

So, as I see it, this is must legislation for this Congress.

Mr. GAVIN. Do you believe, General, this is attractive enough to interest these boys?

General KIRK. We don't know. We are asking for this to start, and then we will see. We don't know. We had difficulty getting approval. We have been working on this now for at least 6 months, to get it to this committee for a hearing. We have to start somewhere. I don't know whether we will do it or not, sir.

Then we have a lot of Regular officers, excellent boys that are up in rank and getting more pay—normally captains that are now lieutenant colonels and colonels and some day they are going to be busted. When they are, they will resign and get out, because they can go out to some town and get more money than they can in the Army. They have to look after their family.

This is an emergency. It isn't something to be offered tomorrow. It is something that should have been done 2 years ago.

Now, the same question was asked as to the dentists. The thing must be studied. Sure, we are going to be in the same situation and have to come to the Congress maybe next year and ask for the same thing as to the dentists that we asked for the doctors this year. I am not so sure, but I think we will. I do know that this is acute in the Medical Corps of the Navy and the Army.

Mr. BLACKNEY. You say, Doctor, we should have a Medical Corps of potentially how many?

General KIRK. In the Army we are asking for 5.5 doctors for each thousand troops. We know that we have to have that many to do the job.

Now, under the 50,000-officer program that Congress authorized, the War Department, 3,000 have been allotted the Medical Corps. So we have to have another 3,000 on extended active duty or hired as civilians to do the job because we are going to need, with an Army

of 1,000,000 men, as the Secretary has told you, around 6,000 doctors. We actually have 1,100 regulars. Under the present separation criteria, next June we will be short 1,500 doctors, and there will be no more ASTP's to take their place.

Mr. BLACKNEY. Could you state, Doctor, the over-all expense of this bill?

General KIRK. I can't. We have it here. I have a piece of paper here in front of me that states the total estimated annual cost to the Government for reimbursement pay would be \$5,760,000. This amount is based on an assumed strength of 4,800 medical officers, for a postwar Army of 875,000. If we had them all, that is what it would cost. Since reimbursement pay would be drawn only by Regular officers and volunteers, the total annual cost to the Government would be substantially smaller during the interim period than the amount stated above. On July 1, 1947, an estimated 1,100 Regular medical officers and 800 volunteers would be eligible to receive reimbursement pay. That is a total of 1,900 officers, as of July 1, 1947.

On the basis of this number, a minimum annual cost for the fiscal year 1948 would be \$2,280,000, the price of about four B-29's. Subsequent annual costs would be increased with additional procurement of volunteers and further integration of Regular Army officers.

It should be noted that while an officer may receive a total of \$36,000 reimbursement for 30 years of service, the average length of service is less and in practice very few officers will ever receive the maximum amount payable. In other words, only about 60 percent of those officers coming in will be in the service 30 years from now—maybe less than 60 percent—because of death, resignation, retirement, and other reasons, so the cost is minimum in comparison to the cost of running an Army, and an army can't be run without doctors.

Mr. BLACKNEY. Mr. Hébert, have you any questions?

Mr. HÉBERT. General, I just have one question to ask. I don't want to amplify on it any more than I have in my questions to the Secretaries earlier this morning, which I believe you heard. However, I want an expression from the individuals who are in charge. It is in connection with the possibility of establishing the Army's own medical school. What is your reaction to that thought?

General KIRK. Well, sir, something must be done about medical education, but I don't believe that is the answer, sir. It is going to take a great expenditure of money to build facilities, and I don't believe we have the patience, the variety of patience, necessary to teach undergraduate medicine. I know we don't have the professors that we would have to have to give that instruction. When a boy graduates in medicine, he is just starting out as a doctor. The treatment of battle wounds, malaria, and the other things that we have to teach those men to make them good officers for the Army and Navy is graduate training and not undergraduate training. It has been stated that there are only 5,000 doctors that can be graduated each year. Then those schools are getting in difficulties financially. Many were private medical schools, built on endowments. There aren't very many more endowments. The income from endowments is shrinking. The other schools are State-supported, which is supported from taxes. Medical schools are having difficulties with their budget, getting the legislature to vote them enough money. The medical

students pay \$500 to \$600 a year tuition, but that only pays about 50 percent of the cost of educating that boy at school.

It would seem to me, sir, it is necessary that this number of doctors be increased that are graduating each year, but I would think it might be better to subsidize the schools to increase the enrollment by 10 or 15 percent, rather than try to start new schools. New schools may be the answer, but it will take 10 or 15 years before they are going concerns. I think it is better that they be done in civil life, rather than by the military forces. It isn't the job of the military forces to do that. It is to give medical service to the Army and Navy and graduate training to the doctors, not undergraduate training. I am afraid the output from the schools wouldn't measure up to what the other schools are turning out today in medicine.

Mr. HÉBERT. General, you have this situation—I quite agree with you but I think the statement advances my argument. The schools are not adequate to turn out as many men as want to become doctors.

General KIRK. Yes.

Mr. HÉBERT. As many of the youth of the country that do want to become doctors.

General KIRK. That is correct, sir.

Mr. HÉBERT. Now, as far as starting a school is concerned, I can't agree with you. I don't take issue with you, but in my State they started a school practically overnight down there, and it has become one of the largest medical schools in the country. I refer to Louisiana State University. They did it overnight, because they had the wherewithal. Money is the wherewithal, with everything, and I am sure they could do it if they had the wherewithal.

Now, it is my suggestion to establish one military medical school, for the training of our own doctors, whereby any youth who wants an opportunity to become a doctor can become a doctor, provided he trades his desire and his talent in for a certain amount of service to his Government in the armed forces. Then you wouldn't confront yourself with the problem of the civilian doctor. There you would have that inlet and outlet to a sufficient number of doctors for your own armed services.

General KIRK. Well, you see, this happens: The ASTP feels he is in servitude now. It was considered whether or not we would recommend to the Congress that we pay this man this \$36,000 which would reimburse him, let us say, for the money that he has spent studying medicine. It pays him off during the 30-year period, that it cost him to study medicine. This money actually does that.

Mr. HÉBERT. I recognize that, but that is an emergency you are facing.

General KIRK. I think something ought to be done, but I think it ought to be done in the big cities, where there are hospital facilities for training, so when we graduate a doctor he is as good as a graduate from Harvard or Hopkins or any other school. It takes more than money. It takes professors and know-how to do the job. I think Colonel Churchill, who is professor of surgery at Massachusetts General, and Dr. Morgan, who was my consultant in medicine during the war, from Vanderbilt, will be here and I think they could give you better advice than I on this subject. I think it is something that must be reviewed thoroughly, though, before any legislation is enacted to carry it through.

Mr. HÉBERT. Naturally, I agree with that, but I don't want to leave your testimony here now as closing the door on this thought.

General KIRK. No, sir. I am sure that that ought to be explored with those people.

Mr. HÉBERT. You are in full accord that it should be explored and if it is feasible it should be adopted. Of course, if it is not, I certainly wouldn't advocate its adoption.

General KIRK. Yes.

Mr. HÉBERT. If it is not a feasible plan.

General KIRK. Of course, it is our aim to get a cross section of the best medical men. If we could get a cross section of the various schools throughout the country, rather than from one school, we could get a better medical service.

Mr. HÉBERT. If you were to arrive at Utopia, yes, but the reason you are here is because you haven't been able to get that Utopian situation. In fact, you can't even get them to stay in the service.

General KIRK. Because we haven't offered them enough to keep them in the service.

Mr. HÉBERT. Even if you offered them enough, your testimony shows that you are not turning out enough doctors to take care of the over-all program.

General KIRK. That is correct, sir.

Mr. HÉBERT. You don't have enough physical facilities to turn out the doctors.

General KIRK. Yes.

Mr. HÉBERT. You just simply can't turn them out.

General KIRK. That is right.

Mr. HÉBERT. Therefore you have to look forward to a plan whereby you can establish the physical facilities to give the youth an opportunity to become a doctor.

General KIRK. There isn't any question about that.

Mr. HÉBERT. That is my whole argument.

General KIRK. That is mine, except I don't think it is the Army and Navy job to do it.

Mr. HÉBERT. Well, they spent billions of dollars—

General KIRK. Not on medicine.

Mr. HÉBERT. That is the point I am making.

General KIRK. Not on medicine.

Mr. HÉBERT. That is just the point I am making. They spent billions of dollars to train men to kill, and have spent nothing to train men to save. It doesn't make sense to me.

General KIRK. The money we get for research amounts to less than one percent.

Mr. HÉBERT. I am for giving the facilities and money to you to train these men.

General KIRK. We haven't got the wherewithal to put on the professors. We haven't got the wherewithal to do it.

Mr. HÉBERT. I want to give you the wherewithal.

General KIRK. We can't even get the lieutenants to come in, let alone that type of professor. We can't get those people for less than \$20,000 a year, sir.

Mr. HÉBERT. If it takes \$20,000 a year, I am for giving them \$20,000 a year to train our medical men.

General KIRK. That is why we are asking for these four professorships.

Mr. HÉBERT. I am with you.

Mr. BLACKNEY. Gentlemen, we thank you. On account of legislative business, we will adjourn now to meet on Thursday at 10 o'clock.

(Captain Nunn requested that the statement of Admiral Chester W. Nimitz, U. S. Navy, be inserted in the record, and the Chairman so ordered.)

(The statement is as follows:)

**STATEMENT OF ADMIRAL CHESTER W. NIMITZ, U. S. NAVY**

Mr. Chairman, the Secretary of the Navy has called to your attention the expected critical shortage of Naval Medical Officers in the near future. This problem is of serious import to the Navy Department and considerable study has been given in planning a method which will alleviate this critical shortage.

The Medical Department of the Navy is a vital component upon which naval operations must depend. The strength of this component depends upon Naval Medical Officers. When postwar plans were made which substantially increased the existing strength over the old peacetime strength, it was recognized that the Medical Corps must be built up mainly by inducing Reserve Officers to transfer to the Regular Navy. The response to this program was very disappointing. A relatively small number transferred. In the meantime, retirements and resignations of Regular Medical Officers have gradually depleted our numbers, largely because of lucrative civilian opportunities. Under the existing situation, replacement by procurement has been and is ineffective.

A stop-gap measure has been in operation for about 1 year, in which we have utilized approximately 2,000 V-12 Government-subsidized Reserve medical officers. We have been able to properly care for our sick and wounded only by this emergency means. I want to emphasize that if some action is not taken our situation will be critically embarrassing. Very shortly we will not have sufficient medical officers to care for the sick and wounded in our hospitals, dispensaries and ships, nor to form a necessary nucleus of medical officers as a solid backbone for any required expansion.

I believe this proposed plan will meet the Navy's needs. I thoroughly subscribe to the proposed legislation and believe that title I of the bill, providing \$100 per month additional pay for all naval medical officers on active duty, should be considered "Must Legislation" by this session of Congress.

**HOUSE OF REPRESENTATIVES,  
COMMITTEE ON ARMED SERVICES,  
SUBCOMMITTEE No. 10, PAY AND ADMINISTRATION,**  
*Thursday, June 5, 1947.*

The subcommittee met at 10 a. m., Honorable William W. Blackney, chairman, presiding.

Mr. BLACKNEY. The committee will come to order and resume its hearings on H. R. 3174, the Army bill, and H. R. 3254, the Navy bill.

We are happy this morning to have with us General Eisenhower.

**STATEMENT OF GEN. DWIGHT D. EISENHOWER, CHIEF OF STAFF,  
UNITED STATES ARMY**

General EISENHOWER. May I proceed?

Mr. BLACKNEY. Have you a statement?

General EISENHOWER. I would rather make merely a few informal remarks, Mr. Chairman.

Mr. BLACKNEY. Fine.

General EISENHOWER. There are present this morning people who know much more about the task we have from the medical viewpoint

than do I, in the person of Dr. Morgan, Dr. Churchill, and General Bliss. They are three men who have been studying this thing intently and earnestly for many, many months, and their conclusions will be far more valuable than anything I could give on the details of this bill.

But I can tell you something of the responsibility that rests upon the military head of the Army, to see that his soldiers are well.

Our people calculate, for example, at this moment that we need something like 6,000 doctors to keep healthy and in proper shape the Army for which we are going to have a need during the foreseeable future. We have now only 1,100 Doctors in the regular officer corps. That is fewer than we had when this war started. In spite of all the integrations we have been able to make, more doctors have gone out than have come in. The gap between these 1,100 and the total number that we need is now made up by a body of doctors recently educated, at least in part at Government expense, and whom we are now able to keep in on a compulsory basis. But that is going to run out, and we are facing a very desperate situation from the standpoint of the military organization. So, in company with these gentlemen and people working with them on our staff, we have been going over the problem, as I say, for many months. We have come up with a solution. We don't even know that this will work, but it is certainly the best thing that we can figure out. We do know that we have got to cast aside all of the old, let us say, prejudices against some favored treatment for a particular type of officer in the Army. We cannot adhere to the principle that everybody, let us say of the grade of first lieutenant, or captain, or major, must be treated identically. We must get doctors. That is the problem we have. We must get good doctors. They have got to be capable of dealing in every field, of course, of medicine, including that of preventive medicine, in which our own doctors have been so successful. On top of that, they have got to be of the quality, Mr. Chairman, to produce what you might call a medical general staff. Otherwise, how are we going to organize this country in war, particularly if we face the kind of war that so many of us fear, one of great destructiveness and terror throughout our country. No longer will it merely be a problem of taking care of the wounded on the battlefield. It is going to be equally the problem of someone to take care of the sick and wounded of great cities, in order that the country can operate at all. There have got to be people that during the years of peace can work out those programs and plans, that will involve not only the personnel we have but the systems, methods, and schemes necessary to keep this country healthy in time of war.

Now, I want to assure you again that I have gone over this thing in most minute detail. While I am not willing to say that any particular detail of it is better than could be devised by someone who knows more about those details than do I, I am prepared to say that we have the very best advice from the military and civil doctors that there are in this country. It is the best scheme they could devise. Therefore, I am not only in favor of it, but I am in favor of its enactment just as soon as it can be done, sir.

That is about the character of my statement.

Mr. BLACKNEY. Thank you, General. That is fine.

You state that we should have a potential strength of 6,000 in the Medical Corps?

General EISENHOWER. The medical officers say, to meet our current needs for a million-man army, which is the strength of our Army for at least the immediate, and immediately approximate future, something like 6,000 doctors, as I recall the figure.

Mr. BLACKNEY. And it is your definite judgment that this bill will be of vital importance in securing, and then retaining, members of the Medical Corps.

General EISENHOWER. Yes, sir. I should say that we will not need 6,000 regular officers because we hope some day this million-man army can be somewhat cut down, but we do need 6,000 now and we will always need far more than we have now. I have forgotten the exact figure, but I think it is something like 3,700 that they figure we are going to need permanently. We can't get them. On the contrary, we are going downward.

Mr. BLACKNEY. You figure the over-all salary increase of \$1,200 would be a part of the inducement that would aid us in securing additional strength?

General EISENHOWER. That whole question of salary came up first, Mr. Chairman, on the basis of reimbursing a man whose education has become such an expensive thing that he has to find ways often of repaying loans that he has received in order to get his education. I believe the increase in salary should have some effect on getting us more doctors, yes, sir.

Mr. BLACKNEY. General, have you given any study to the title that provides for the four professors?

General EISENHOWER. I merely know that they want these four experts, or consultants, or professors in the Office of the Surgeon General, to advise him constantly and to help him in every phase of his job. I think the idea was to get a preeminent man in civil life. The idea is to have there the best men that our Surgeon General can gather around him all the time.

Mr. BLACKNEY. And it is your judgment that that would be practical and efficient?

General EISENHOWER. I think it would, sir, for this reason: These men in civil life do get reputations that are brighter possibly among their own people, their own profession, than they are among us who hope to stay healthy. We call the doctor only when we are sick, but they are thinking of that man all the time.

Now, I know successful organization means successful leadership and men follow other men in whose professional attainment they take pride. So if we can gather around the Surgeon General men whose names become known in civil life, just as sure as you are a foot high it will tend to have them swarm around him and to get behind him, to be known as students or followers of those people. That is my belief on that, Mr. Chairman.

Mr. BLACKNEY. This figure of 6,000 doctors is predicated on an Army in peacetime of 1,000,000 men.

General EISENHOWER. I am giving you figures, Mr. Chairman, now that I have remembered from about 3 months back. If I have made any error on the exact number General Bliss or one to follow me will correct me, but those are approximately correct. For the 1,000,000-man army that we are going to need as far as we can see for certainly several years, we must keep 6,000 men on active duty.

Mr. BLACKNEY. And the passage of this bill as speedily as possible in your judgment is advisable?

General EISENHOWER. Very emphatically so. I believe it thoroughly. We must do something instantly.

Mr. BLACKNEY. Mr. Andrews?

Mr. ANDREWS. No questions.

Mr. BLACKNEY. Mr. Cole.

Mr. COLE. Mr. Chairman, the thing about this bill that intrigues me and arouses my curiosity is—and I would like to inquire—what there is about it that makes it of such a nature as to cause the Secretary of War to come down and testify for it, the Secretary of the Navy to come down and testify for it, and the Chief of Staff of the Army to come down and testify for it. I can only conclude from that fact that you gentlemen, of such other responsibilities, taking the time off to come down here to testify for it, indicates its importance.

General EISENHOWER. Mr. Cole, I can't imagine what would happen in this country if, when these so-called ASTP doctors go out, we could put one-fifth of the doctors in Japan that we would need. I can't imagine what would happen. I believe that occupation would come rattling around our ears. That would have such terrible repercussions throughout the world, in its present state of uneasy equilibrium, I don't know what would happen. I am certain that we cannot keep these people all over the world, in these foreign stations, unless we have adequate medical care.

Mr. COLE. Do you agree that the reason I suggested as to why these gentlemen to whom I have referred have taken the time to come down here to testify on this bill is a striking indication of the importance of it?

General EISENHOWER. I am sure that your implication is absolutely correct.

Mr. COLE. Frankly, General, I am not too greatly impressed with this four professors' idea—not that the Medical Department of the services shouldn't have intermittently, from time to time, the highest specialized skill in the country, to spend a little time in going over the establishment or visiting the schools, but it occurs to me that that talent is readily available to the Department on a voluntary basis, rather than on a hired-man basis.

General EISENHOWER. I doubt, Mr. Cole, that any of our people—who will meet you this morning—will say that that is absolutely vital to success. I think they would regard it as one of the factors that should help us, but since they are the technicians in this field I would prefer they support the particular point, rather than I.

Mr. COLE. Do you know—and very likely you may not know—whether the Medical Department of the Army has ever contacted a nationally prominent specialist in any particular medical field and asked him to spend a week or two in going over some problem that the Department might have and that individual has refused.

General EISENHOWER. Of course, I can't answer that question—I don't know—but I do know this, sir, that in the last 6 years, since it began to look like we were going to get into war, I have never known of any nationally prominent man that refused to give us a week of his time when we asked for it. However, in time of peace we can't forget the saying that "God and the soldier we adore when danger threatens, not before."

Mr. BLACKNEY. One more question, General. Should the dentists be incorporated in this bill?

General EISENHOWER. Again, I will have to refer you to General Bliss. I don't know enough of the differences between the dental problem and the medical problem to answer, sir.

Mr. BLACKNEY. Mr. Hébert?

Mr. HÉBERT. Yes, Mr. Chairman.

General Eisenhower, when the Secretary of War and the Secretary of the Navy were here the other day we agreed that this was merely a piece of emergency legislation, that it would not solve the problem for the future, and that we have to approach it with our sight trained on higher horizons. Among the suggestions that we discussed for a long range program was the possibility of the armed services educating their own doctors.

General EISENHOWER. Yes.

Mr. HÉBERT. In other words you have a West Point for your soldiers. You have an Annapolis for your sailors. Why wouldn't it be logical to establish a medical school, financed by the Government, to train the doctors for all the armed services? What is your reaction to that thought?

General EISENHOWER. Well, if you will allow me in discussing it to extend it a little bit; very naturally, when you find a shortage of anything you set out to increase the supply. When I came home from Europe and they began to tell me of the condition, I said, "Gol darn it, what have we done about getting busy and getting a lot more medical schools established." I found, to my horror, what was involved in the business of establishing a medical school, getting its facilities and particularly its faculty. It seems, also, that it requires something of a reputation before they will turn out a doctor that these higher doctors will call a good doctor. I've just run into a stone wall, with every proposal I have made.

Now, I hadn't considered the one of trying to educate our own, but I am certain in the early periods, with a new school like that, we would not get the good ones because the young doctor of talent, the man that has gone through his pre-med course, would rather go to the Virginia School of Medicine, or Pennsylvania, or Harvard, or down to Vanderbilt with Dr. Morgan, one with a reputation, than to go to this school merely because it was governmentally run.

In the long run, though, I would agree with you this far: There is no answer to this thing except to increase the supply of the doctors in the United States, because I think it is going to affect the civilian as well as the soldier sooner or later.

Mr. HÉBERT. There, General, you have in effect—I will amplify what you said in my own words—agreed with me that the medical school by the Government is one of the solutions. Now let us be practical about this whole thing and let us approach it very realistically.

General EISENHOWER. Yes.

Mr. HÉBERT. There are so many young men in this country who have a desire and a talent to be a doctor. Of course, the desire to be a doctor is 50 percent of the battle, anyway. A medical education is perhaps the most expensive of all educations in our institutions of learning today. There are many young men who have the desire,

the talent, and the potentiality of becoming good doctors who do not have the finances.

General EISENHOWER. Yes.

Mr. HÉBERT. So they naturally abandon that career early and the country has lost a good doctor. Now, wouldn't it be logical in a case like that for the Government to tell this young man that they would train him for a certain period of years, and in return he would stay with the Government in the armed services. That takes care of that individual.

Now, as to your statement that there aren't sufficient doctors, of course there are not sufficient doctors. The reasons why we could probably explore at great length. We all have different opinions as to why they don't have them.

General EISENHOWER. Yes.

Mr. HÉBERT. But the fact does remain that there are only 70 so-called A medical schools in this country, with the physical capacity of turning out some 5,000 doctors a year. There is no thought given to increasing the output of those schools. As a matter of fact, certain individuals would rather see the number decreased or held down so as to hold a good monopoly on the doctors of this country. I recognize that.

The whole thought is projected into the idea that we are health conscious. We are becoming more health conscious, with the national social insurance program. Instead of a decreased need of doctors in the future, we are going to need more doctors.

General EISENHOWER. That is right.

Mr. HÉBERT. Now, every boy, as you indicate, would like to go to Tulane or to Vanderbilt, or to Rush Medical in Chicago, or to some of the top flight schools, but he just can't get in, even if he has the money. George Washington University, it was testified the other day, has 80 vacancies in the freshman class and 1,500 applicants. That means 1,500 boys who do have the finances, who do have the wherewithal; can't get in. They are going to abandon a career.

So, to get back to my suggestion, if it is practical and feasible, don't you think it is a good idea for the Government—not necessarily the Government, but the armed services, to educate their own doctors and bring them up into the service? We can't transgress into the other field now, General. We have to solve our problem. Let the other fellow take care of his side of the fence, in the national program. Let us solve the Army and Navy problem right now.

General EISENHOWER. Well, I should think that our own professional men in the services would be the best equipped to answer that question, because they have both the knowledge on the medical professional side of this thing and they know the Army's needs. They have known the Army medical problem for years. I would say, as a layman and knowing nothing about this medical problem, if you will make it on the basis that we need ordnance technicians or we need some other kind of technicians, I would say we would jump in and train them ourselves. Whether we can train doctors or not, I don't know.

Mr. HÉBERT. Naturally, you can do anything. I mean, that has been proven. You personally proved that to a great extent. Anything can be done if you have the wherewithal.

Now, as far as starting a medical school is concerned, it is not so terribly hard to do if you have the money to do it. If you have the money to attract the professors, you will do it. A gentleman in Louisiana, who is now deceased—I won't call his name—some years ago didn't like another university in the State. He started a medical school over night, and it is a pretty good school, the Louisiana State University Medical School, down there. He had the wherewithal to do it and he attracted the talent. The same thing has been suggested up here: If somebody would offer us \$50,000 a year they could get 435 Members of Congress to serve, very rapidly. So if the Government has got the money, has got the wherewithal, they can start a medical school.

Mr. GAVIN. You can cut that in half and you will still get 435 members.

Mr. HÉBERT. Cut it in half. I am just indicating that if you have the wherewithal, if you have the money and the attraction, you can do it. Your very appearance here today is in behalf of giving them more money, to attract them.

General EISENHOWER. That is right.

Mr. HÉBERT. Don't you think it is a logical thought for the Government? You spend billions of dollars to kill people and hardly anything to save their lives, in the armed services.

General EISENHOWER. That is right.

Mr. HÉBERT. I think, last year, of all the money expended by the Navy, 2.3 percent went for saving and the rest of it, for killing. That doesn't make sense, does it?

General EISENHOWER. No.

Mr. HÉBERT. So you would agree, if it is practical, we should have such a scheme.

General EISENHOWER. As a layman in this field it seems to me it is a logical thing, but I do find, in talking to people like Dr. Churchill, Dr. Morgan, and Dr. Elliott Cutler, you have this problem: Dr. Cutler has really given his life to this thing. He is a very, very sick man, and I know he has nothing but the interest of his country at heart. He has said we must take a bill like this, rather than go into the other field first. I will tell you what he said. He said it will be 15 years before you begin to get really worth while help. He goes on to take the time to build your institution, the time to acquire the faculty, and the time to get it started. Then, I think—I have forgotten—it is 9 years after a fellow starts his medical education before they call him a doctor, nowadays. So it is 15 years, or certainly at the minimum 11, before you would begin to get returns from this investment in your school. We have got a problem now.

Mr. HÉBERT. Certainly, General, you have got a problem that is going to take 15 years, but if we wait it will be 15 years, and then 15 more years, and we still won't have any.

General EISENHOWER. I agree.

Mr. HÉBERT. So we had better start right now thinking about it.

General EISENHOWER. We have certainly got to start now increasing the output of doctors in this country, if we are going to meet the need.

Mr. HÉBERT. That is correct. Yet you have resistance from certain quarters where resistance shouldn't come from.

General EISENHOWER. I won't resist.

Mr. HÉBERT. I know you won't. I just wanted your opinion as a layman.

Mr. BLACKNEY. Mr. Heffernan.

Mr. HEFFERNAN. General, are you in favor of this bill as it is?

General EISENHOWER. Yes, sir; I am.

Mr. HEFFERNAN. Would you have any objection, where the word, "medical" appears, if we put in "and dental"?

General EISENHOWER. I have no objection. However, I don't know the problem as to that particular thing. As represented to me, the dental officer can secure his education and be a satisfactory man before you can do it in the broader field of general medicine or surgery. That is what was represented to me. There is some little difference between them in the time it takes for their education. That is all.

Mr. COLE. Mr. Chairman—

Mr. BLACKNEY. Mr. Cole.

Mr. COLE. May I inquire of General Eisenhower?

Mr. BLACKNEY. Yes.

Mr. COLE. Pursuing the thought advanced by Mr. Hébert, General, has the Department given any consideration to continuance of the ASTP training program, as far as doctors are concerned?

General EISENHOWER. No, sir; I think not beyond the provisions of the present bill. If there is anything that has been done on that, or any consideration, again General Bliss would have to answer. It hasn't been brought to my attention.

Mr. COLE. That training program has been discontinued, has it?

General EISENHOWER. I think so.

Mr. COLE. It seems to me, if the shortage of doctors is as acute as you indicate and the future outlook is as dark as it appears to be, it might be well for the Army to revive the medical training program.

General EISENHOWER. I think now it has become a question of capacity of the schools of our country as they now exist. That is the limiting feature. The only thing that we got under it was compulsory service out of these people. That is my understanding.

Mr. COLE. If the demand for the training of doctors appears to be a stable one for the indefinite future, I am confident there are enough private resources and interest to establish the school.

General EISENHOWER. I wish they would hurry up.

Mr. COLE. Yes; but as it is now, the demand for the training of doctors is solely from the civilian phase of it. I suppose it is anticipated that this demand will be shortlived, that 3, 4, or 5 years from now the demand for medical training will level off. On the other hand, if a program of Federal subsidy of medical training can be established, which would indicate that the demand for medical training would be a permanent one, then there would be a basis on which private interests could be induced to establish the school.

General EISENHOWER. Well, of course I agree with the general principle, that when you get private interests to do such things it is always preferable, rather than to get bureaucracy doing it, but as I understood Mr. Hébert, with this desperate shortage, if we had such an institution nationally known and would always be at least, you might say, a stabilizer in the whole situation, we would have one certain source of these people. However, we do need doctors in the country, not only in the Army and Navy.

Mr. BLACKNEY. Mr. Gavin.

Mr. GAVIN. General, I don't know whether you want to comment on this or not, but General Bliss brought out the fact the other day that in this Army specialized training program we educated 9,000 or 10,000 American youth in the medical profession. Recently, in seeking medical men for the service, they had but 218 applications. Now, we expended for each one of these students, according to General Bliss, approximately \$14,000 or \$15,000. It is amazing to me that more of them haven't responded. When we educate a youth at the Military Academy or the Naval Academy he seems to have a love of service, a devotion to duty, and they follow the service as a career, but here we provide boys with a medical education and opportunity and we only have a response of 218 out of 9,000 or 10,000 men. What is the reason that we didn't indoctrinate them more with the ideals of the service, to interest them in carrying on in the medical profession for the United States service.

General EISENHOWER. I think there are two reasons, Mr. Gavin, that could be quoted. First of all, they came in the service in time of emergency, when the only time you had was not to teach traditions and ideal of service and the satisfaction that is derived merely from serving your country. You had to put them to work. That is what we had to do, as fast as we could. Often they worked under conditions not those that they had dreamed of, in a quiet hospital somewhere, but under rather inconvenient circumstances.

The second thing is the terrific competition for them now in civil life. Some of my doctor friends have told me that any doctor can go out and hang up his shingle nowadays and make two, three, or four times what he can make in the Army. To the young fellow, that means a lot. He is getting started in life. Maybe he is repaying loans and maybe he is trying to get married or just has gotten married. This opportunity of immediate return is quite striking.

Now, the ordinary graduate from West Point and from Annapolis has had 4 years of training in which the ideals of the service have been up before him. On top of it, there is ordinarily—unless he is a Davis or a Blanchard or something like that—not terrific competition from civil pursuits for his services.

So I think while the figure 218 is a disappointingly small figure, I believe the considerations that have applied there, the factors that have led most of them back into civil life, are perfectly explainable in terms of human desire and ambition.

Mr. GAVIN. Well, I would say there is equally as much opportunity for a West Point or Naval Academy man in civil life—maybe not as great as for a doctor, but the civil service examination applications that come across my desk for economists at \$8,000 or \$9,000 and statisticians at \$8,000 or \$9,000 a year. A boy with the kind of an education such as he receives at the Academy could step out of the service if he so desired and qualify for a \$8,000 or \$9,000 a year job. The opportunities are there for him just as well as for doctors, but he elects to remain in the service for which he has been trained.

General EISENHOWER. That is right.

Mr. GAVIN. But in planning that ASTP service, after making this investment in a boy's education we certainly should have given thought to the length of service he was to serve after he had graduated.

General EISENHOWER. I agree there.

Mr. GAVIN. Two years and an additional year on a voluntary basis.

General EISENHOWER. Yes.

Mr. GAVIN. That should have been considered, in planning.

General EISENHOWER. Right.

Mr. GAVIN. For the investment we were making, we ought to have gotten greater returns.

General EISENHOWER. Right.

Mr. GAVIN. Now we have these men available and 218 out of 9,000 or 10,000 have indicated a desire to return to the service, to sort of repay this country for the investment we made in them. It was a very fine educational program, and it may be that it should be continued to reach the desired results that we are talking about here today. I don't know what your opinion——

General EISENHOWER. I don't know too much about it. After all, I was a little busy while this was going on, Mr. Gavin.

Mr. GAVIN. I do appreciate that fact, General. We are proud of you. Now for a second lieutenant. Out of the academies he receives \$2,160 a year. He certainly has the same ambitions that you have been talking about.

General EISENHOWER. Yes.

Mr. GAVIN. The medical man.

General EISENHOWER. Yes.

Mr. GAVIN. The boy for the academies when he graduates he thinks about getting married, raising a family, and also enjoying life. He should have enough to make ends meet. There is a vast differential here, in our whole set-up, that must be considered in any pay increase, whether or not increasing the pay of the medical profession is going to make other branches of the service feel that they have been discriminated against. A readjustment of this whole pay schedule may eventually have to take place, because of the fact that we are now establishing a precedent. In that connection I would like to call your attention to the statement of the gentleman from New York concerning the dentists. That profession is going to immediately present a case and say, "Well, why the exception? The medical profession gets an increase and not the dental profession." It is one thing I think we should consider in the bill, so we don't have that backfire later on.

General EISENHOWER. I agree with you, sir. Personally, though, I think this, that the pay of every Army officer and every Navy officer below the grade of general officer is far too low. I don't know what the peak is going to be eventually, so as to attract the right kind of man in your armed services that you will need. But here, in all the discussions I have had about this, Mr. Gavin—and I assure you it has been months we have been fighting back and forth on this—we come back to this hard fact: We haven't got the doctors and we can't get them. No matter what has been done in the past, what mistake has been made, whether some one erred in judgment or not in providing the leadership, maybe, that might now have gotten 1,000 instead of 218, we are right up against it: We haven't got the doctors. That is the reason I have been supporting this bill, Mr. Gavin.

Mr. GAVIN. You conscientiously feel that this bill here is the answer to the problem, and that we will get the doctors if we grant this increase.

General EISENHOWER. I say it is the most reasonable thing that has been suggested to me, that I think has a chance of getting the doctors, Mr. Gavin. That is all I can say.

Mr. BLACKNEY. General Eisenhower, we are very glad that you came. We appreciate your statement.

General EISENHOWER. Thank you very much.

Mr. BLACKNEY. Thank you for being here.

Dr. Churchill.

General BLISS. May I introduce Dr. Churchill? Dr. Churchill is the John Homans professor of surgery at Harvard. He has been past president of the American Surgical Association. During the war Dr. Churchill was our chief consultant in surgery in the Mediterranean theater. He has been awarded many decorations for his work. He is one of the most prominent physicians in the United States. I will sit down, if I may, with Dr. Churchill.

Mr. BLACKNEY. Dr. Churchill.

#### **STATEMENT OF EDWARD J. CHURCHILL, M. D., JOHN HOMANS PROFESSOR OF SURGERY, HARVARD UNIVERSITY**

Dr. CHURCHILL. I have no prepared statement at all. I simply wish to discuss extemporaneously the problem which some of us have been trying to advise General Bliss and General Kirk, as well as Mr. Patterson and General Eisenhower.

Now, we have had to take a very realistic point of view. I am not here as an apologist for the medical profession at all. We simply will have to deal with the facts as this committee tried to advise the War Department, in facing what seemed to us a desperate situation. This not only involves the care of the soldier in the peacetime Army, but it is going to have, as General Eisenhower pointed out, a very definite morale effect on the American parents whose sons may desire to serve in the Army as volunteers.

Now, Dr. Morgan and the other members of my committee have worked very closely together, and with your permission I should like, in saving your time, to let Dr. Morgan deal chiefly with titles I and II, and I shall turn my attention to titles III, IV, and V, trying to point out to you the reasonings in the minds of the committee members in making these recommendations which later the War Department translated into the bill that you are considering.

I might say, in passing, that titles I and II, in regard to the pay increase, we have considered perhaps less important in the long range point of view than these other titles, which I think may be more or less obscure to certain laymen.

Now, in title III, I am not at all surprised that this question of professors in the Army has been raised. I wish there were another title. We hesitated to use the term "professor" but we did find that there is a precedent in the War Department for that title, that there are three professors, I believe, at West Point and it could fit within the precedents and the framework of the War Department.

Our conception of positions, though, which we are recommending is not that ordinarily considered as "professor." These men, we believe, should be chosen on the basis of their professional competence

and standing. That is the first and very essential step in elevating those standards throughout the Medical Corps, so that doctors will begin to be attracted on a professional basis of the practice of medicine and its specialties.

Now, there was rather an interesting experience that I think very few people were aware of, but early in this war there was a temporary lag in the volunteers. You see, no doctors were drafted. All doctors in World War II were volunteers. There was a little hesitancy right after Pearl Harbor on the part of civilian volunteers to come in. Then the Surgeon General's Office did a very interesting thing. They brought Dr. Fred Rankin from Kentucky as the chief consultant in surgery. They brought Dr. Morgan, of Nashville, as the chief consultant in medicine. They brought Dr. Menninger, of Kansas, as chief consultant in neuropsychiatry. The moment those men appeared in uniform, in Washington, in the Surgeon General's Office, the bottleneck of the civilian volunteering was broken and immediately the civilian doctors came into the Army.

Now, with that lesson, we believe, if we can establish, surrounding General Bliss, leadership that represents the highest standards of doctoring, of professional service, we will take one step forward in breaking this bottleneck of procurement.

We would visualize that these men would be given authority by General Bliss for the training and the education and the assignment of men in specialist fields, on which the civilian doctor places a great deal of emphasis at the present time. He may be right in this or he may be wrong, but it is a fact that he does. We also visualize that these four men representing the important fields of medical professional service in the Army may stimulate the research program in war planning.

We like to picture that they will be advisers to the administrative groups headed by General Bliss. In other words, we are trying to picture a projection of the consultant system as it was developed in World War II into the peacetime Army. I was consultant in the Mediterranean theater. Dr. Cutler, my colleague, was a consultant in surgery in the European theater. I could name dozens of other leaders in civilian practice who assumed just this role, not only in the Surgeon General's Office but in the overseas theaters.

Now, rather than take this man and put him behind a desk in the Pentagon Building, we believe he should be in active contact with the young professionally minded doctors of the Army. For that reason, we have suggested that he have professional privileges at Walter Reed, being perhaps the titular chief of his service there, so that he is in contact with surgery, in contact with neuropsychiatry, visualizing the patient's and the young doctor's problems.

So what we are suggesting here is a tested scheme, not any new idea of setting up what might be called a professor. It is a functional mechanism of operating that has been tested.

Now, in title IV, in which we have recommended the bringing in, at the level including full colonelcy in the Army, of such men, as strong men as we can find willing to join the Army from civilian life, these men would be in the major hospitals, the general hospitals of the Army Medical Corps. They would carry the work load, their portion of the work load, in teaching and in training, both functions of which are highly desired by the young doctor today.

Now, in title V, we are suggesting that as enabling legislation. General Eisenhower has said that he hopes to carry the officer load of his million-man Army by Volunteers from the Reserve on extended active duty. With the authorized strength of the Medical Corps up to 2,700, we will still have a gap of 3,000 officers that the War Department is anticipating securing from their Reserve volunteering for periods of extended active duty. I just don't believe we are going to get that many men to drop their practice, particularly the young men who have had their work interrupted by the war—and there are 40,000 of them—leave their families and go in for a period of extended active duty in army medicine.

Now, if it is possible to carry some of the work load in this country by these men, as the Veterans' Administration is carrying it, then I think we may have enough to supplement it, but we are doubtful about the extended active duty from our reserve.

That is all the statement I care to make.

Mr. BLACKNEY. Doctor, you look upon the four professors, then, not as a theoretical proposition but as a practical proposition that will be of benefit to the Medical Corps, is that right?

Dr. CHURCHILL. That is our picture of them. They are chief consultants. They are what Dr. Morgan was and what Dr. Rankin was during the war. The title "professor" will enable certain special provisions which may attract your better men to those jobs.

Mr. BLACKNEY. You say you have tried to think of some other name than the professorial name in designating these four.

Dr. CHURCHILL. I think it is a perfectly suitable title because we have the precedent in West Point.

Mr. BLACKNEY. What will be the salaries of these four professors?

Dr. CHURCHILL. Those would be comparable to the rank, which is either brigadier general or major general.

Mr. BLACKNEY. And that would be how much?

Dr. CHURCHILL. I would have to ask General Bliss that.

General BLISS. It is not very much.

Mr. BLACKNEY. Well, somebody furnish me that later. I also want a general statement from some witness—

General BLISS. \$6,600 a year.

Mr. BLACKNEY. As to the potential salary that these Medical Corps officers receive, high and low.

General BLISS. \$6,600 a year is the pay of a major general.

Mr. BLACKNEY. Yes. I also want somebody to testify a little later as to the income of the civilian medical personnel.

General BLISS. We have that all on charts, Mr. Chairman.

Mr. BLACKNEY. Can you, Doctor?

Dr. CHURCHILL. The Department of Labor—

General BLISS. We have it all on charts to present here shortly.

Dr. CHURCHILL. Yes.

Mr. BLACKNEY. Mr. Cole.

Mr. COLE. Doctor, aren't these type of men that you have in mind for the purpose that you contemplate under title IV available on a voluntary basis, rather than on, as I expressed to General Eisenhower, a hired-man basis? Certainly money means nothing to the specialist of the type you have in mind. He has already earned and laid away all he needs to take care of himself. I mean, money isn't a factor.

Mr. GAVIN. We hope.

Mr. COLE. Because if money is a factor, what you are going to pay him under this isn't going to be any inducement for him to come in. It is the quality of public service that is going to cause him to come in and do the job that you think should be done.

I wonder if the Government can't obtain the services of this type of person for a year or two, which this bill indicates is the extent that you are going to use these specialists, and in that way instead of having four—I see you shake your head when I say they are only going to use them for 2 years. Then, if they are going to use them longer than for 2 years, you are going to have only four nationally prominent men in the medical service of the War Department who are going to be lodestones to attract younger doctors. The other way, by obtaining voluntary services of equally prominent specialists you can, through a series of rotation, get a higher number of highly qualified specialists, than you can under this system.

First let me ask: Don't you think that a specialist, such as yourself, would be willing to spend a year or two out of his life working for his Government for nothing?

Dr. CHURCHILL. Well, Mr. Cole, I have already spent three or four in the war, but just how much longer my university might be willing to have me work—

Mr. COLE. I am not asking you to commit yourself.

Dr. CHURCHILL. No, but I am bringing out the point that we, all of us, in civilian life, except those in free-enterprise private practice, are fairly well burdened with other responsibilities. I think there is no better evidence than the fact that this committee, of which I am chairman, have spent an enormous amount of work in the past year on this problem. We have organized the doctors who served as consultants both in this country and abroad into a group of 160 men. They met here in Washington last fall. They are all delighted to give their time and help the Army Medical Corps. They have recently formed a smaller committee, at the request of General Bliss, to review the educational program of the young doctor in the hospitals of the Army. Those men are working. We are giving our time right today. But we still believe that for continuity, General Bliss should have at his elbow day after day a permanent man. This man is not limited to 2 years. He is a permanent man who can stay until his retiring age. That man should know every young officer in his special field in the Army by name, know his ambitions, advise with the personnel officer in regard to assignments, give these young fellows some sense of security against arbitrary action by the War Department in their personnel problem, which as you know is always an enormous one.

Mr. COLE. Give whom some sense of security? The professor?

Dr. CHURCHILL. The young doctor—the feeling that some one is going to help him attain the professional standards which he hopes to attain.

Mr. COLE. You don't have in mind the professor, one of these professors.

Dr. CHURCHILL. Pardon me?

Mr. COLE. When you speak of insecurity, you are not thinking of these four professors.

Dr. CHURCHILL. I am thinking of him giving the young doctor that he is trying to attract into the Army that sense of professional interest.

Mr. COLE. Well, if the professors are to be on a permanent basis, that fact, in itself, operates towards stagnation.

Dr. CHURCHILL. Works towards stagnation?

Mr. COLE. Yes.

Dr. CHURCHILL. That is why we don't want him behind a desk. We want him living in the hospitals part of his time.

Mr. COLE. That is right, but you say once he is appointed and comes on the job he is there permanently. My question is, doesn't that very fact, that he is to be there permanently, operate towards stagnation?

Dr. CHURCHILL. Well——

Mr. COLE. Toward his losing of interest.

Dr. CHURCHILL. Well, perhaps, then, all of our universities have stagnated. I wouldn't want to argue that point. We are all on permanent appointment in our universities, in just this field.

Mr. COLE. What is the difference between title V and title IV? Both, as I read, are designed to authorize the appointment of specialists.

Dr. CHURCHILL. You see, the way we are now operating, no doctor can be commissioned in the Regular corps over the grade of major—correct?

General BLISS. First lieutenant.

Dr. CHURCHILL. Over the grade of first lieutenant. We believe there are a few men throughout the country of sufficient age and reputation who might be still attracted to come in, by careful screening at a higher rank.

Mr. COLE. Is there anything in the law that prevents the War Department from commissioning a doctor above the rank of lieutenant?

General BLISS. Yes, sir. That is just getting around the law. There is no other implication there.

Mr. COLE. I say, does the present law prohibit the War Department from commissioning a doctor above the rank of lieutenant?

Dr. BLISS. First lieutenant; yes, sir.

Mr. COLE. The law prohibits it?

General BLISS. Yes, sir, except in this integration, where we could take them up through the grade of major, but that is over. The only way you can come into the Army Medical Corps is to come in as a boy out of medical school. We are trying to get them so they will come in in some of the higher grades.

Mr. COLE. Isn't the only difference between the two titles that the first title relates to the appointment of a specialist in the grade of colonel and the other title relates to specialists in the grades below colonel?

Dr. CHURCHILL. Title V, Mr. Cole, is the enabling bill which will provide some means of carrying the work load, particularly in the hospitals in this country, for a million-man Army, when our organized strength of the Regular corps is only 2,700. That is comparable legislation which Congress passed enabling the Veterans' Administration to man their hospitals.

Mr. COLE. That is title V.

Dr. CHURCHILL. Title V; yes.

General BLISS. Mr. Cole, perhaps I could answer that a little more clearly to you. That is only a qualification as to the men that we

would take in. We won't take in men in these grades unless they are specialists and so qualified before they come in. The other one, that Dr. Morgan is going to talk about, means that we will attempt to qualify our specialists in the service. Taking in the men over the rank of first lieutenant is a qualification which they will have to possess.

Mr. COLE. Doesn't the War Department currently have authority to hire contract physicians and surgeons?

General BLISS. Yes, sir.

Mr. COLE. How does that authority differ from the authority under title V, especially section 506?

General BLISS. We can hire consultants now at \$40 a day, a certain limited number at \$40 a day. That title V is the exact counterpart of the Veterans' Administration set-up, where they were able to come in on a full-time, part-time, or any other basis that you could get them to come in on. We are limited at the present time in hiring consultants at \$40 a day.

Mr. COLE. Does this authority of title V permit you to go beyond \$40 a day?

General BLISS. Yes, sir. Starting at the lower grades, it is all the way up to and including \$10,000. We can only take these consultants in now up to 90 days in a year. This would let us take a man in on the basis of any arrangement that we could make with him. For example, a man could come in for 6 months, or for a year, or for 3 months. It is just getting around the laws which stagnated and prohibited the Veterans' Administration from functioning. It is the exact counterpart of what they have now.

Mr. COLE. Why do you in this bill limit yourself as to the temporary full-time doctors to 90 days? Under section 506 you are limited in the employment of temporary full-time doctors to 90 days.

Mr. GAVIN. What do you mean by temporary full-time?

Mr. COLE. I suppose that means that the doctor is on the job all hours of the day, but the tenure of his employment is temporary.

General BLISS. That is a legally written document, and I can't explain all that. I have tried to get the implications of it. It covers all the laws of the country. It is accepted as the law and has been written in legal documents before. What we want to do is get full- or part-time men if we need them and as we need them.

Dr. CHURCHILL. It is identical with the Veterans' Administration.

General BLISS. Yes; it is identical with the Veterans' Administration.

Mr. COLE. You can do that now, except the law limits you to \$40 a day and to not more than 90 days of the year.

General BLISS. That is correct.

Mr. BLACKNEY. Any other questions?

Mr. GAVIN. I would like to ask General Bliss how that term "professorships" was determined. Why were they called "professors"?

General BLISS. They will be called "general" when they come in the Army.

Mr. GAVIN. What?

General BLISS. They will be called "general" when they come in the Army.

Mr. GAVIN. Yes, but "professors," as we have gotten to know them over the past several years, are usually economists or statisticians.

Now we are talking, from Dr. Churchill's testimony, about advising and consulting specialists. When a Member of Congress gets this bill and he sees "professorships" he immediately wants to know about the professor. When Dr. Churchill explains that these men are advising and consulting specialists, that puts an entirely different aspect on the whole situation. I think it should be corrected, to put in the bill what these men actually are. They are not professors—well, they are in one sense of the word, but really they are advising and consulting specialists, men of unusual ability in specialized fields, and they should so be recorded here, so that a Member of Congress who reviews this bill on the floor of the House won't be confused.

General BLISS. That is correct.

Mr. GAVIN. And it seems we wouldn't be able to explain the situation unless we had Dr. Churchill with us. I want to say his explanation to me this morning has been very satisfactory. I think some consideration should be given, Mr. Chairman, to establishing some other name than "professors." They are really men who because of their ability are recognized as outstanding in the profession and we are seeking now to attract young men into the service, to be given the opportunity to work with these men of recognized ability or specialists in their profession.

General BLISS. Yes, sir. Our consultant system as established during the war was one reason, and the main reason, that we had the wonderful results which we did have in professional work in our Army during the war. We never had that consultant system before the war. "Professorship" as such has a precedent in the Army and is an Army term, rather than meaning just what it says. There are professors in the Army at West Point. He is an Army officer, but he is under the designation of "professor," which perhaps protects him from some of the machinations of the War Department. He stays at West Point. He is a professor there for the rest of his life. Our professors will stay with us and not be subject necessarily to foreign service, unless we want them to go on foreign service. They are not necessarily subject to all the laws which come up about keeping a man in Washington for 4 years, or things like that.

Mr. GAVIN. Well, these men are entirely different than a professor at the Military or Naval Academy.

General BLISS. We have our own academies, too.

Mr. GAVIN. I realize that, but we are seeking men of outstanding ability in the particular professions. I think there should be some designation—it is merely my opinion—other than "professor."

General BLISS. I think there would be no objection to calling them anything else, would there?

Dr. CHURCHILL. I would like the War Department to study that. We were informed that the title of "professor" would immediately protect that individual from, as General Bliss says, certain of the changes of assignment, prolonged station in Washington, and would set him apart a bit from the promotion list officers.

Mr. GAVIN. Doctor, name some outstanding member of the profession, regardless of who it may be?

Dr. CHURCHILL. Dr. Fred Rankin, who is a consultant.

Mr. GAVIN. You wouldn't call him "Professor Rankin."

General BLISS. They would be called general officers.

Mr. GAVIN. You would feel rather strange calling him Professor Rankin. Certainly we don't want to call him Professor Rankin here. It doesn't sound correct to me. I am merely trying to ascertain the reaction as we bring this bill out, to discuss it with the Members of Congress. I think he ought to be called doctor, or a consulting medical specialist, or whatever particular title he is entitled to for the particular position that he occupies in his professional life. I merely bring that to the attention of the committee for its consideration.

Mr. BLACKNEY. Doctor, I wonder if you could give me some idea with regard to this: How many outstanding specialists would be attracted by a salary of from \$8,000 to \$10,000 a year, even with the 75 percent retirement pay?

Dr. CHURCHILL. This is in reference to these four positions?

Mr. BLACKNEY. Yes.

Dr. CHURCHILL. It certainly wouldn't compete for the man who places the great emphasis on his earning power, in the competitive trade of surgery or medicine, or whatever he is doing. I believe the opportunity to develop a field within the Army Medical Corps might appeal to a few men, particularly if it provided him with some opportunity to get from behind his desk, go to the hospital and teach some of the younger men, taking a personal interest in their professional growth.

Mr. BLACKNEY. Now, with reference to that professorship, I want you to understand that I have the highest respect, of course, for our professors in universities and colleges.

Mr. GAVIN. I might add that I also have the same high regard for professors but as a layman I think this designation should be made clear in the bill.

Mr. BLACKNEY. The only thought in my mind is we want to pass a medical bill. Will that term be a deterrent on the floor of Congress—the use of the term "professor" instead of some other title that means the same?

Mr. GAVIN. Could I interject at that point——

Mr. BLACKNEY. I am looking at it from the practical standpoint.

Mr. GAVIN. I don't think it would be a deterrent, but I think it wouldn't be clear what they really were. That is what I am trying to bring to the attention of the committee.

What we are talking about, Doctor, is a medical specialist constlstant. I don't think our calling them professor would be a deterrent in any way, but nevertheless I think they ought to be called really what they are.

Mr. BLACKNEY. Have you any conclusions on that, doctor?

Dr. CHURCHILL. Mr. Blackney, I think the important thing is to have these four men, with the provisions essentially as we have outlined. I don't care what they are called. That is in your own sphere of competence and not mine, as to getting legislation passed.

Mr. BLACKNEY. Doctor, that is fine. We appreciate your statement.

Mr. HÉBERT. Mr. Chairman, may I ask the doctor a few questions?

Mr. BLACKNEY. Yes, but remember we have two witnesses to hear yet before 12 o'clock.

Mr. HÉBERT. I just want to get the doctor on record, Mr. Chairman. It is along the same line of questioning I pursued.

I was very interested in your statement, Doctor, that the reason this bottleneck was broken during the war was because some eminent doctors put on a uniform. My impression was the reason it was broken was the threat of conscription of doctors. They tried to beat the gun. They didn't rally around because the uniform was put on some outstanding doctors. The bottleneck was broken when they understood doctors were going to be drafted, too.

Following your line of thought and reasoning, then the only thing necessary now would be to eliminate title I and II and have some eminent doctors enter the service and then these young men would be eager to join the service. We don't need titles I and II, do we?

Dr. CHURCHILL. I prefaced my remarks, sir, by saying Dr. Morgan would speak on I and II.

Mr. HÉBERT. I am asking you your opinion. You say the reason the bottleneck was broken during the war was because eminent doctors put the uniform on. Now, we probably could have your four eminent doctors put on the uniform and the young doctors would really get into the service and rally around them.

Dr. CHURCHILL. Doctors have to eat, also.

Mr. HÉBERT. I recognize that. One other question I want to ask you and that is the question I proposed to all the other witnesses. What is your judgment in connection with the establishment of an armed services medical school?

Dr. CHURCHILL. Well, sir, I think that is a very thought-provoking challenge. That is one of the questions that I should think would require very serious study. The so-called shortage of doctors is under study at the moment by many different agencies, including governmental agencies. What the final conclusions will be, I don't know. That is very largely in the hands of the deans and the presidents of our universities and medical schools. I qualify as neither one.

Mr. HÉBERT. Well, you do think that it is a field that should be explored?

Dr. CHURCHILL. I agree thoroughly it should be explored. It is one that has been touched upon by our committee. I would also say, if it were ever to be done, if the Medical Department of the War Department wished to have a medical school, the provisions of this bill would be the very best background for reaching that goal.

Mr. HÉBERT. Well, you know, Doctor, there is no thought—probably there is thought, but there is no indication of immediate action to increase the capacity of our medical schools in this country, is there?

Dr. CHURCHILL. That is under study, I understand. I am not on any committee which is concerned with it.

Mr. HÉBERT. But you don't know of any particular indication that the physical capacity of the schools, which have only a limited capacity of 5,000 doctors a year will be increased in the near future.

Dr. CHURCHILL. I know of no definite plans.

Mr. HÉBERT. So it is a physical impossibility to turn out more than 5,000 doctors from grade A schools.

Dr. CHURCHILL. We seem to be running at a maximum capacity.

Mr. HÉBERT. We are going to need more doctors in the future and the only way to get more doctors in the future is to have more schools, or a greater capacity than the present physical set-up of our schools.

Dr. CHURCHILL. We must always balance that against quality, also, sir. We have the problem of distribution of doctors, as well as the actual numbers of doctors. Doctors distribute themselves like filling stations and grocery stores, in our present free enterprise economy.

Mr. GAVIN. That is the way they should.

Dr. CHURCHILL. That is the way we should; yes.

Mr. HEBERT. We are in agreement with that, but I think we could have more than 5,000 able doctors if more young men were given the opportunity of educating themselves. The fact is that many young men who want to be doctors and who are able and talented enough to be doctors, can't be doctors because they don't have the physical set-up to educate themselves. They are turned away by the thousands from our leading medical schools each year and are compelled to pursue some other endeavor in life.

However, I just wanted your expression on the thought of the armed services at least doing something tangible and concrete about it and perhaps starting their own medical school. I am glad to hear you concur in my opinion on it.

Mr. BLACKNEY. Doctor, we thank you very much.

Dr. CHURCHILL. Thank you.

Mr. BLACKNEY. Doctor Morgan, will you state your name and title to the stenographer?

General BLISS. May I introduce him to the committee. Dr. Morgan is professor of medicine at Vanderbilt University. He was our chief consultant in medicine in the Surgeon General's Office during the war. As such he had complete charge of all of our medical policies. He traveled many times around the world and is intimately familiar with our medical problems.

Mr. BLACKNEY. Dr. Morgan.

#### **STATEMENT OF HUGH J. MORGAN, M. D., PROFESSOR OF MEDICINE, VANDERBILT UNIVERSITY SCHOOL OF MEDICINE**

Dr. MORGAN. Mr. Chairman and gentlemen—

Mr. BLACKNEY. Have you a statement?

Dr. MORGAN. I have no prepared statement, sir. I would like to speak from notes.

Mr. BLACKNEY. Yes.

Dr. MORGAN. First I would like to support the chairman of the Secretary of War's advisory committee, Dr. Churchill, who just preceded me, in placing emphasis upon titles III, IV, and V in this bill. They are essential. They should be discussed first by any member of our committee, because our committee felt that these were the absolute essentials.

Title III: The creation of chief consultant in medicine, surgery, neuropsychiatry, and preventive medicine, with the title of professor, if you please, but whose job would be that as indicated, namely, chief consultant, providing leadership to young men who might be interested in the Army, is a procurement device, if you please. Our whole approach as a committee was to do something about procurement, because that was the problem that was facing the Medical Department of the Army.

I might say, with regard to the use of the term "professor," because that interests the committee evidently, good medical practice is based on continuing education. Doctors are very used to the term "professor." My predecessor as a witness here is a professor of surgery and is known throughout this country and the world as a professor of surgery, doing more I believe to develop surgery in World War II than any single man, developing the practice of surgery and the forwarding of the specialty of surgery.

I would like to say that title IV, which will bring into the Army high-grade, outstanding men to help these four chiefs do their job, is absolutely essential, if we are going to create a professional environment in the Medical Department which will be attractive to young men who are looking for a career in medicine.

I would say that title V is essential, because we don't think that title III and IV will do the job. If you don't have a backing up by available civilians, bringing them in, the job can't be done at the high standards which the Medical Department of the Army sets for itself.

Now, my assignment is to talk about titles I and II. As was pointed out by General Bliss this morning, it is like talking about the threads that hold the horsehide that covers the baseball. Titles I and II are essential to this bill, in my judgment, but they aren't the horsehide. The horsehide that covers the bill is titles III, IV, and V. Titles I and II are important, and I think essential. I don't think they can be left out, either one of them. The bill as a whole is designed to provide a professional atmosphere in the Army that will be attractive to young men and that will make it possible for young men to envision a professional career in the Medical Department of the Army. In order to do that we have to get personnel which in this country is in short supply, and doctors are in short supply. I won't belabor the committee with a great mass of statistics, but I will just point out a few reasons why doctors are in short supply. In the first place, the total population of the United States, according to the Bureau of Labor Statistics, has increased some 43 percent since 1910. The doctor population during that same period has increased 13 percent. In the second place, the population now existing in the United States is an aging population. People are living longer and require more medical care the older they get. In the third place, medicine as a profession is infinitely more efficient and effective than it has ever been before and doctors' services are being required by people more than ever before. In the fourth place, there is an increased demand for doctors by Government. The Army wants five times more doctors than it had before the war. The Navy wants three or four times more than it had before the war. The United States Public Health Service is in short supply for doctors. It needs them desperately. The local State health services need them desperately. Over a third of the counties of the United States haven't got a full-time public health officer. There is a vacuum in terms of doctor needs, in terms of supply for doctor needs. The Veterans' Administration is requiring 4,000 more doctors than it did before the war. All that adds up to thousands of doctors in terms of shortage. Dr. Parran, of the United States Public Health Service, estimates that by 1950 there will be a shortage of something like 30,000 doctors in relation to doctor needs, as compared with our situation I think in 1940. I am not sure about

those figures, and figures don't mean too much to me—I am not a statistician, but there is, we will all agree, a tremendous need for more doctors in the United States. In the face of that need, there is more or less a fixed supply; 5,200 are graduated annually. Our committee is studying this, the Secretary of War's advisory committee is studying this. We believe this is a problem which is not only an Army problem, though that is the problem which is our specific interest and which led us into this, but this is a national problem. As Dr. Churchill stated, the matter of supply is under study by our committee.

I think it is fair to say, then, that the Army—that is the problem at the moment and that is the thing I think I know a little bit about—is in need of personnel from a market which is in short supply and which is in a favorable economic position. I would like to make a few points with relation to the economic position of the doctor in this country. According to the Bureau of Labor Statistics, in 1939 the average income of the doctor was \$4,470. In 1943, it was \$8,688. In 1939, only one-sixth of the doctors of the United States had a gross income of over \$11,500. Over half of the doctors in 1943 had an income of over \$11,500, gross. In 1941—and this may interest you—for the first time in history the average earnings of doctors exceeded those of lawyers in the United States.

That all has a bearing on title I. It is perfectly obvious that increasing the salary by \$100 a month isn't going to solve the problem economically. As I pointed out, I don't think that is important. I don't think it is important to try to compete actually in terms of dollars and cents with civilian life and its opportunities, with industrial medicine and its opportunities, but one does have to face up to the situation that the doctor is in a favored economic position, and if you want doctors that has to be recognized.

The specialist pay, the justification of that item, which would give the specialist an additional income above that of the general practitioner in the Army, finds precedent in the legislation which was passed for the Veterans' Administration and which is working very effectively in the Veterans' Administration. It is the fact that the specialist in medicine earns more, his earning capacity is greater, than the general practitioner.

Finally, I think I would like to say that any procurement program—and that is what we are talking about, that is what this bill is designed for—for the Army must take these facts into consideration: The demand from civilian life, industry and the Veterans' Administration is great and the emoluments are attractive. They are attractive both from the point of view of professional advantages and from the point of view of financial return. The only realistic approach is to try to meet this type of competition as best we can, for the Army. The Veterans' Administration has made a good start in this direction and is succeeding in its mission. Men are leaving the Army and the Navy to go into the Veterans' Administration. If you pass this legislation, you will put the Army at least on a parity, in terms of competitive ability, with the Veterans' Administration. The bill constitutes an integrated plan for the emergency which the Army finds itself in.

In my judgment, each item of the bill is essential to the success of the plan as a whole. I believe we have, in the leadership of General Bliss and his deputy, efficient, effective administrative officers to carry this through. I believe, if the bill is passed, we at least will

have done the best we could to give them the tools to carry out the mission which they are charged with. I believe that anything short of this bill will be leaving them leaning on a pretty weak reed in terms of the future, as we see it, in the cold facts of reality.

Mr. BLACKNEY. Doctor, that is a fine statement. Can you explain why titles III and V in the Army bill have no counterpart in the Navy bill? Aren't the needs in the naval service similar?

Dr. MORGAN. Mr. Chairman, I don't feel prepared to speak relative to the needs of the Navy. My entire experience has been in the Army. We were charged with the Army problem. We tried to hew to the line.

Mr. BLACKNEY. We will get that later, then. Any questions? [No response.]

If not, Doctor, we thank you.

Dr. MORGAN. Thank you.

Mr. BLACKNEY. Admiral Swanson.

#### STATEMENT OF REAR ADM. CLIFFORD A. SWANSON, SURGEON GENERAL, UNITED STATES NAVY

Admiral SWANSON. Mr. Chairman, the Secretary of the Navy has presented to you certain factual data relative to the present medical officer personnel situation in the United States Navy.

We have here a chart, chart No. 1. It may be noted that out of the present authorized medical corps strength of 4,315, we have on board as of April 21, 1947, 3,736 medical officers which include 476 who are on duty with the Veterans' Administration and the Public Health, leaving a net of 3,260 on duty in the Navy.

On July 1, 1947, out of an appropriated strength of 3,798, we expect to have on board 3,513, including the same 476 on duty with the Veterans' Administration and the Public Health Service, or a net of 3,037 on duty in the Navy.

On July 1, 1948, out of an estimated appropriated strength of 3,781, we expect to have on duty 2,263.

On July 1, 1949, out of an estimated appropriated strength of 3,000, we expect to have on board 1,050 medical officers.

It is readily evident that the deficiency of 1,055 naval medical officers on active duty with the Navy is expected to increase by July 1, 1949, to a deficiency of 1,950.

The bill, as proposed, has three essential features:

(a) Title I provides that commissioned officers of the Navy Medical Corps shall be paid the sum of \$100 for each completed month of active service; provided, that such sum shall not be included in computing the amount of increase in pay authorized by any other provision of law or in computing retired pay; and provided further that this increase is not retroactive and that the total amount which may be paid to any one officer under this authority shall not exceed \$36,000. This title also provides that commissioned officers of the Medical Corps of the Naval Reserve who may volunteer for extended active duty for a period of 1 year or longer be included.

(b) Title II provides for 25 percent increase in base and longevity pay for Medical Corps officers of the Regular Navy and Naval Reserve who are certified as specialists by an American Specialty Board, and recognized by the Surgeon General of the Navy. Officers so designated

under the provisions of this title shall retain such designation, with the additional pay incident thereto, until it is withdrawn upon recommendation of the Surgeon General. Medical officers receiving specialists' pay would not be allowed to receive flight pay or extra pay under other provisions of law, and in no event could they receive both increases at the same time, but could receive either one, whichever is greater. This increase is not applicable in computing retired pay.

(c) Title III provides that the President, by and with the advice and consent of the Senate, is hereby authorized to make original appointments to permanent commissioned grades, with rank not above that of captain, in the Medical Corps of the Navy in such numbers as the needs of the service may require. Such appointments shall be made only from civilian medical and surgical specialists who have been certified as specialists by the American Specialty Board and recognized by the Surgeon General of the Navy. The appointees must be citizens of the United States, and must have such other qualifications as the Secretary of the Navy may prescribe. The physicians and surgeons so appointed shall be carried as additional numbers in rank, but shall not increase the authorized number of commissioned officers of the Medical Corps of the Regular Navy.

The Secretary of the Navy is authorized to prescribe from time to time such regulations as may be necessary for the administration of title III.

It is estimated that the total cost of this bill for the fiscal year 1948, with an average number throughout the year of 3,096 medical officers on active duty, will be \$3,752,600, of which \$3,715,200 will be occasioned by title I and \$37,400 by title II. This is the estimated approximate cost of one destroyer escort.

This proposed legislation will make a career in the Medical Corps of the Navy more attractive to physicians and surgeons by authorizing additional compensation to reimburse them for their excessive expense and time involved in their education with resultant postponement of the earning period of their lives.

It is believed that a plan similar to the Navy's officer candidate training program would not meet with favorable response from medical schools at this time. State-supported medical schools would be reluctant to support such a program because the State would in no way benefit from the program. At the present time, medical schools are able to accommodate approximately one out of each five applicants for admission, and they are not in position to increase their enrollment to meet any increase in the number of students that might become necessary should such a plan be adopted.

If candidates were selected for training and sent to medical schools at Government expense, there is no assurance that such candidates would successively complete their medical education and be commissioned in the Medical Corps of the Regular Navy. Further, the plan would be of no actual assistance for 5 years.

The plan contained in the proposed legislation is believed to be the most desirable one in that it would have an immediate effect upon procurement of medical officers, and would tend to eliminate the present great number of resignations from the Regular Navy Medical Corps. It is the most economical plan, since the payment is made only to officers who have proved their worth and their desirability for duty in the Medical Corps of the Navy.

I would like to present to you chart No. 2. This chart shows a comparison between the average income of a specialist in obstetrics and gynecology in 1943 and the average income of all physicians in 1943 against the average income of medical officers in the Veterans' Administration and in the Navy at the present date. The figures applicable to the Navy would be equally applicable to the Army. The figures shown are \$20,219, which is the gross income of one practicing obstetrics and gynecology in 1943. The average gross income in 1943 of all physicians is \$13,713. The average income of medical officers in the Veterans' Administration without the specialist pay is \$6,123, and the average income of medical officers in the Army and also in the Navy is \$5,164.

Now, chart 3: The average gross income of all physicians in private practice in 1941 to 1945, as compared to the Veterans' Administration physicians and Navy medical officers as of the present date. We see that the average civilian physician income is, in 1941, \$8,625; 1942, \$11,150; 1943, \$13,713; 1944, \$14,620; and 1945, \$14,392. This may again be compared with the Veterans' Administration average of \$6,123 and the Navy average of \$5,164. The data for this come from the Bureau of Foreign and Domestic Commerce of the Department of Commerce, from the office that issues the publication Survey of Current Business.

Chart No. 4: This is a comparison in pay scale between Veterans' Administration physicians and Navy medical officers, broken down into grades. In this chart the available 25-percent increase afforded Veterans' Administration specialists is omitted.

Practically all medical schools require at least 3 years' college work leading to a bachelor's degree for admission. However, because of competition among prospective medical students, the majority of these students obtain a bachelor's degree before entering medical school.

From the foregoing, it can be seen that a candidate for a commission in the Medical Corps of the Regular Navy has spent 8 or 9 years in training, and, as a result, enters upon his career in the Navy 4 or 5 years later in life than the general officer who graduates with an academic degree and enters upon a service career.

The period of time the medical student spends in basic science in college corresponds to the time the general officer spends in academic training. During the 4 years in medical school, the medical student maintains himself and pays at least \$500 per year for tuition and fees. In most cases, during the fifth year of his medical training or internship the medical student is paid little or nothing but is furnished quarters and subsistence for himself. During the 5 years the prospective candidate for a commission in the Navy Medical Corps is in training at his own expense, the contemporary general officer has received approximately \$18,000 in pay and allowances. Therefore, when the medical school tuition is added, the Medical Corps officer begins his period of naval service at a disadvantage in relation to the other officer equal to approximately \$20,000, and this does not include the cost of subsistence for the medical student while in medical school. Members of the medical profession are well aware of this disadvantage and it is becoming more and more difficult to procure physicians and surgeons for the Medical Corps of the Navy. The additional pay which would be authorized by the proposed bill would

gradually reduce the difference between cumulative earnings of the general officer and the medical officer until the difference would be practically eliminated at the end of 30 years' service.

Now, we have here another chart. This chart is a comparison of the accumulated earnings of general and medical officers based upon 30 years' work, after graduation from an initial 4-year college course. Let us consider two young men just graduated from a normal 4-year college course. A goes into medical school and is later commissioned in the Navy Medical Corps. B is commissioned an ensign in the Navy. At the end of 30 years following graduation, let us compare their cumulative earnings. The medical officer has during this period earned a total of \$138,000. The general officer has earned an accumulated total of \$165,000, which for comparative purposes, may justly be raised by 3 percent compound interest on the difference available each year to \$191,000. This is the situation under the present law. Under the proposed bill, these cumulative totals would be more nearly equalized, where the medical officer would earn \$168,000. That compares very well with the general officer's earnings of \$165,000, which may rightly be increased for comparison purposes by 3 percent compounded interest to a total of \$175,000.

The next chart: This chart presents in graphic form the same data as were visualized in the chart preceding. Under the proposed bill, the medical officer's cumulative earnings surpassed that of the general officer in the twenty-third year, and here again for comparative purposes from the twenty-third to the thirtieth year he—the medical officer—is charged with 3 percent compound interest on the difference. The net difference, with the interest factor included in both, would be \$6,900, still in favor of the general officer.

Now, the next chart: This chart is a comparison of applications for commission with the available billets for both general officers and medical officers. It will be visualized here that applications for commission in other than the Medical Corps afforded 169 percent of the needed personnel to fill the available billets. On the contrary, only 16 percent of applications were received of the number of medical officers required for the available billets.

The Navy Department has recommended enactment of this proposed legislation and this bill is similar to the corresponding titles of the bill which has been approved and recommended by the War Department. Furthermore, the proposed title II corresponds to the present existing law, which provides 25 percent increase in pay for medical specialists now employed by the Veterans' Administration.

Though personally I am quite enthusiastic, we do not believe that titles IV and V of the Army bill will be necessary for the Navy. However, the Bureau of Medicine and Surgery intreposes no objections to inclusion of these two titles in the legislation. In fact, we look with some favor on the four professorship idea.

Mr. BLACKNEY. Thank you, Admiral. In view of those intriguing figures you gave with reference to civilian practice, is this \$1,200 increase going to be a sufficient inducement?

Admiral SWANSON. We have explored the situation somewhat and we believe that if title I is-enacted it will prevent resignations and will also aid very materially in recruitment. That is based on our unofficial Gallup polls.

Mr. BLACKNEY. Admiral, would you care to make any statement as to whether or not the dentists should be included in this bill?

Admiral SWANSON. Yes, sir. Mr. Chairman, the purpose of this bill is to present a means of meeting the impending acute shortage of medical officers in the Navy at this time. There is not at present such an acute shortage of dental officers. The intake in this corps has about balanced the output. Since VJ-day in the Dental Corps of the Navy—and I received these figures from the Dental Division of the Bureau of Medicine and Surgery—124 resignations of the Regular Navy Dental Corps have been received, as contrasted with 117 dental officers who were commissioned. Also, the average medical officer's training requires 4 years in college, 4 years of medical school, and one year in internship, or a total of 9 years. The average dental officer's preliminary education consists of about 2½ years in college and 4 years in dental school, or a total of 6½ years.

The Dental Division has been studying the dental officer personnel situation, but the study is not as yet complete.

Mr. GAVIN. Who is the Chief of the Dental Division?

Admiral SWANSON. The Chief of the Dental Division at the present time is Admiral Chandler.

Mr. BLACKNEY. Are there any questions?

Mr. GAVIN. How many vacancies do you have now in the Dental Division, Admiral?

Admiral SWANSON. Admiral Chandler is in the room.

Mr. GAVIN. Well—

Admiral CHANDLER. About 800 regular dental officers below the appropriated strength, but these billets are largely filled now with 713 Reserve dental officers.

Mr. GAVIN. Then, you apparently have a shortage, too.

Admiral CHANDLER. Yes, sir.

Mr. GAVIN. What is the differential now between a medical officer's and a dental officer's pay? Any?

Admiral SWANSON. No, the pay is precisely the same. There is one disparity, however, and it is in favor of the dental officer. For instance, when we take a student out of medical school and bring him in as an intern in the Navy, he stagnates that 1 year and does not pick up what in Navy parlance we call a line running mate, so that his counterpart in the dental service, when he comes in, has 1 year's seniority over the doctor. In other words, he becomes a lieutenant more rapidly than the medical officer.

Mr. GAVIN. It is quite evident from your charts, Admiral, that you have statisticians over in your Department, as well as doctors, I would say.

Mr. HÉBERT. Mr. Chairman.

Mr. BLACKNEY. Mr. Hébert.

Mr. HÉBERT. Just one question, Admiral. Just for the purpose of the record, I will ask you your reaction to the proposal of an armed services medical school.

Admiral SWANSON. I think your suggestion is a very thought-provoking question, Mr. Hébert. We in the Medical Department of the Navy are going to explore this.

Mr. HÉBERT. You are in favor of exploring it?

Admiral SWANSON. We certainly are, sir. However, your plan would not be effective at once.

Mr. HÉBERT. I recognize that.

Admiral SWANSON. This legislation is so urgent that we need it now.

Mr. HÉBERT. That is natural. I mean, this is a stopgap. I am looking for a long-range program.

Admiral SWANSON. We have other plans which may aid this whole problem, but they haven't crystalized as yet. I would be very glad to talk to you informally at some period.

Mr. GAVIN. Admiral, what success are you meeting in maintaining the personnel for carrying on your research work, such as we have seen out at Bethesda?

Admiral SWANSON. Well, I believe that is predicated wholly on the enactment of the Medical Services Corps legislation. Since that bill passed the House, we have had quite a number of applications for this Corps.

Mr. GAVIN. That is very fine work and it should be carried on.

Admiral SWANSON. Thank you, sir.

Mr. BLANDFORD. Mr. Chairman.

Mr. BLACKNEY. Mr. Blandford.

Mr. BLANDFORD. Admiral, I would like to ask Admiral Chandler if he has the figures available, to take the chart that Captain Gilmore has, in relation to the deficiencies that you are going to have with your doctors and compare that with—

Admiral SWANSON. Mr. Blandford, Admiral Chandler at the present time is exploring this whole thing very thoroughly. He is cognizant of the whole thing. They have not completed the study. If we find out that this same deficiency exists in dentistry, we would favor legislation putting them on a parity with this. At the present time I don't believe he is quite prepared, because they are studying this whole matter at this time. Is that correct, Admiral Chandler?

Admiral CHANDLER. Yes, sir.

Mr. BLANDFORD. Could you tell us, Admiral, when you think your studies will be completed on that subject?

Admiral CHANDLER. In about a week's time, sir.

Mr. BLANDFORD. In about a week's time?

Admiral CHANDLER. Yes, sir.

Mr. BLANDFORD. Are those figures for appropriated strength, Admiral, sufficient to meet the Navy needs?

Admiral SWANSON. Yes, sir, for the appropriated strength.

Mr. BLANDFORD. And the figure on the first of July, 1947—is that a deficiency of 285?

Admiral SWANSON. The deficiency of 285 plus the 476 with the Veterans' Administration and Public Health Service makes a total deficiency of medical officers on board as of July 1, 1947, of 761 officers.

Mr. BLANDFORD. And it is estimated that we now have a deficiency of 800 dentists?

Admiral SWANSON. I can't verify that figure, sir. I do not believe at the present time that it is considering the Reserves on duty. I think we have an adequate supply of dentists at the present time.

Mr. BLANDFORD. I was just thinking: On those figures you would have a greater shortage of dentists than you do doctors.

Admiral SWANSON. I do not believe so, considering the total officers on board in each corps. We would be desperately short at the present time of medical officers were it not for the fact that, as you

see on the bar chart, the brown part of the bar is for our V-12's. They are the people that prevent the shortage. I think perhaps a similar situation is applicable to the Dental Corps.

Mr. BLACKNEY. Admiral, the data you gave us with reference to officers necessary is predicated on a Navy of what size?

Admiral SWANSON. The appropriated strength Navy. For instance, the enlisted strength of the Navy as of today is 425,000. The enlisted strength of the Marine Corps is 90,000.

Mr. BLACKNEY. Any other questions?

Mr. GAVIN. I have a question.

Mr. BLACKNEY. All right.

Mr. GAVIN. If Mr. Hébert has nothing more.

Mr. HÉBERT. I am through.

Mr. GAVIN. Dr. Morgan referred to a study that was being carried on relative to increasing the facilities in our educational institutions to turn out more doctors. When will that study be completed. Doctor?

Dr. MORGAN. Perhaps you will ask the chairman of our committee to answer that question. The study is under way and the report will be made to the Secretary of War relative to it, insofar as it affects the Army. Of course, as I said when testifying, it is my personal judgment that we are confronted with a national problem. It isn't just the Army or the Navy that is in this fix. The Nation is in this fix.

Mr. GAVIN. That is the viewpoint I am taking, too, that it is a national problem.

Dr. MORGAN. I can't say when that report will be filed with the Secretary of War.

Mr. GAVIN. Well, if it is possible, I think the members of the committee would be very much interested in receiving a copy of that report, when it becomes available.

Dr. MORGAN. Yes, sir.

Mr. BLACKNEY. Thank you, Admiral.

Admiral SWANSON. Thank you, sir.

Mr. BLACKNEY. General Bliss.

Before General Bliss proceeds, I would like to ask Admiral Swanson if he could give the committee some idea as to when we can get this data pertaining to the dentists.

Admiral SWANSON. I will have the complete data on the whole Dental Corps situation to you by tomorrow, sir.

Mr. BLACKNEY. Fine.

Now, General BLISS.

#### **STATEMENT OF MAJ. GEN. R. W. BLISS, SURGEON GENERAL, UNITED STATES ARMY**

General BLISS. If it pleases the committee, I have two prepared statements here. Every bit of it has been covered. I will leave the statements for the record, and if I may, I will have General Denit, our deputy for plans, just rapidly show the charts, due to the shortness of the hour. Then I will be glad to answer any questions.

Everything has been covered, I would say.

Mr. BLACKNEY. All right, your statements will be included in the record.

(The statements referred to are as follows:)

So long as the country is to have an Army that Army must have proper medical care. Due to the world-wide disposition of the Army forces, and due to the responsibility of furnishing total medical care, not only for the sick and wounded, but also the practice of preventive medicine, which is a highly specialized branch of medicine and in which Army medicine has always been in the foreground with the Walter Reeds and the Gorgases and so long as the country has an Army its technical staffs must and of course should plan and prepare for any eventualities of the future. Every branch of the Medical Department is an essential cog in the completed whole but the Medical Corps, the doctors, form the wheel on which all of these cogs are built. Without this wheel everything in Army medicine stops. Under our present system of procurement we cannot get these doctors and ways and means must be devised now to get them—not years from now but now. I believe this bill will accomplish the ends we seek.

In assuming my duties as Surgeon General of the Army this week I realize the tremendous responsibilities facing me. I have the deepest concern over the present state of the Army Medical Corps.

I come to the Congress asking them to help retain that which has always been a credit to the country and to enable us to rebuild on a foundation of rock.

STATEMENT OF MAJ. GEN. R. W. BLISS, SURGEON GENERAL, UNITED STATES ARMY

PURPOSE OF H. R. 3174

The purpose of this bill is to procure physicians and surgeons for the Medical Corps of the Army. It contains those recommendations which the Secretary of War's Civilian Medical Advisory Board believe essential to insure an adequate medical service for the Army. Unless immediate measures are taken, the Medical Corps of the Army will be short 3,900 officers of meeting the postwar need for doctors should the emergency be terminated. This bill contains five titles as follows:

Title I gives Medical Corps officers, Regular Army or non-Regular volunteers, with less than 30 years' service, additional pay of \$100 per month. It is a frank recognition of the undeniable fact that if doctors are to be procured for the Medical Corps they must receive compensation in some measure comparable to their earnings in private practice. Justification for the payment of extra compensation to officers of the Medical Corps is found in the following facts.

The physician enters the Army at a later age due to the fact that he must have completed his medical education which requires longer preparation than most other professions. During the 4 years that the prospective Medical Corps officer spends in medical school at a cost of \$2,000 in tuition and fees, and during his year of internship, his brother officer, already commissioned in the Army, has received approximately \$18,000 in pay and allowances. The Medical Corps officer thus begins his service at a disadvantage in relationship to his brother officer in an amount equal to approximately \$20,000. At the end of 30 years of service the gross cumulative earnings of the non-Medical Corps officer exceed that of the Medical Corps officer by about \$29,000. If the Medical Corps officer is paid \$100 per month additional upon his entrance in the service the difference between his cumulative earnings and the cumulative earnings of the non-Medical Corps officer is eliminated at the end of 30 years. The estimated annual cost of this title, for a Medical Corps of 4,800 officers, is \$5,760,000.

Title II furnishes an incentive for specialists to remain in the Medical Corps and for Medical Corps officers to qualify as specialists, with the ultimate view of maintaining and improving the standards of medical practice in the Army. The need for medical and surgical specialists in the Army is obvious. During the war a large number of specialists were recruited from civilian life but the majority have returned or are returning to private practice. Their place must be filled if the Army is to maintain its high standards. The standards of medical care directly affect procurement since physicians and surgeons will not be attracted to the Medical Corps unless its standards are high.

To qualify as a specialist an individual must be certified by a recognized American specialty board. All members of the Medical Corps, Regular or non-Regular, may qualify as specialists. During the time that such officers hold the designation of specialist the bill provides that they will receive an increase of 25

percent of their base and longevity pay. This title is similar in content to those sections of Public Law 293, Seventy-ninth Congress, which grant the Veterans' Administration the same facilities. The eventual annual cost of this title, assuming that 30 percent of a Medical Corps of 4,800 officers would be specialists, is estimated at \$1,630,000. It would take several years to build up this specialist strength.

Title III provides for the establishment of four professorships in the Medical Department. The purpose of this title is to secure outstanding men in the fields of medicine, surgery, neuropsychiatry, and preventive medicine to act as consultants to the Surgeon General and as professors and practitioners in their specialties at the principal Army hospitals and teaching centers. In order to maintain high professional standards it is desirable to bring into the Medical Department, from time to time, men who have achieved recognition in the principal fields of medicine so that their guidance may be available to the Medical Corps and so that their services may be utilized at hospitals and teaching centers. Professors of the Medical Department would have a status similar to professors in the Military Academy. They would hold an assimilated rank equivalent to that of brigadier or major general and would receive the pay and allowances of their assimilated rank. The annual cost of the four professorships is estimated at \$38,500.

Title IV enables the War Department to make original appointments in the Medical Corps of outstanding medical specialists in grades above that in which appointments can now be made and at ages above present maximum age limitations. From time to time the services of outstanding medical men become available to the Medical Department but because of statutory restrictions these men, who are usually above the age for commissioning and who are financially unable to accept a low rank, are lost to the Medical Department. This title would allow specialists certified as such by a recognized American specialty board, to be commissioned in any grade up to and including that of colonel. The grade in which such specialists would be commissioned would be determined by the nature of their qualifications. No additional cost is anticipated from this title since the specialists appointed would be within the authorized strength of the Medical Corps.

Title V authorizes the Secretary of War to employ civilian physicians to supplement the officers of the Medical Corps if such becomes necessary and to obtain such civilian physicians without recourse to civil service. The Medical Department hopes to discharge its mission with commissioned personnel, but if its procurement program is unsuccessful it will be necessary to supplement the Medical Corps with civilian personnel. This title is similar to Public Law 293, Seventy-ninth Congress, under which the present Department of Medicine and Surgery of the Veterans' Administration was established. The requirements for appointment, the terms of employment, the pay which they would receive, are all similar to that provided for the Veterans' Administration. Inasmuch as any civilian physicians appointed would replace officers of comparable rank within the authorized strength of the Medical Corps, no additional cost would result from this title.

#### NECESSITY FOR BILL

The proposals herein offered are believed to represent the most appropriate solution for the problem of procurement.

The Medical Department has studied plans to subsidize the education of prospective Medical Corps officers as well as plans to establish a medical school and has concluded that neither was suited to the needs of the Medical Department.

Without inducements such as the present bill provides the Medical Department entertains little hope of maintaining a corps of sufficient strength to carry out its assigned mission. The Medical Corps, comprising 48,000 officers at the height of the war, has just completed its most difficult assignment to providing medical service for an Army of 8,000,000 men in all parts of the world. The nucleus of this wartime expansion was the small peacetime Medical Corps. If the Medical Corps is to provide adequate medical attendance to the peacetime Army and to be available for future eventualities, the passage of this bill is essential.

#### STATEMENT OF MAJ. GEN. R. W. BLISS, SURGEON GENERAL, UNITED STATES ARMY

I should like to outline briefly the problem that the Army faces in securing adequate numbers of properly qualified doctors, and the way in which the bill before you will help to solve this problem.

General Denit, my deputy for plans, will later outline the provisions of the bill and give you the supporting information.

The Medical Department of the Army is charged with the responsibility of providing adequate care to the soldier in peace and in war. This includes prevention as well as treatment of disease and injury. It also includes the responsibility for continuous research to improve the standards of preventive medicine and medical care. The remarkable record during the last war, written in terms of lives saved, was due in large measure to the work of the Medical Department, not only during the war but also during the peacetime years preceding the war.

To perform our mission properly, and it must be performed properly, a minimum of 6,000 doctors will be needed by the Army. We have only 1,100 doctors who will remain in the service 6 months after the termination of the emergency. This means that we must find ways and means to induce 4,900 additional doctors to volunteer for service in the Army.

We have tried! Every channel open to us was utilized in urging the medical officers who have done such splendid work during the war to apply for commissions in the Regular Army Medical Corps. We finally succeeded in commissioning 218 officers. At the same time, 350 medical officers retired or resigned from the corps. In short, instead of gaining ground we actually lost ground. While the rest of the Army had more than 5 applicants for every vacancy we had 3 vacancies for every applicant.

I am painting the picture black because it is black. Unless constructive action is taken it will become even blacker.

I believe the present legislation represents the type of constructive action that we need. The doctor is a professional man. This means that he can only be happy in this work if he can grow professionally. This he can do only under the guidance of mature teachers. From many points of view, gentlemen, I consider the establishment of the four professorships and the authority to make original appointments of outstanding medical specialists among the most important elements of the bill. I am supported in this by the attitudes expressed in a recent survey of the young doctors on active duty. This survey indicated clearly that unless they have an opportunity to practice a high type of medicine they would not consider the choice of the Army as a career. We do not now possess, in the Regular Army, the medical specialists who can provide this leadership, but if you approve this bill such leadership can be obtained. Titles III and IV were written with that purpose in mind.

To say that the young doctor is primarily motivated by professional considerations does not imply that he is completely unconcerned with pecuniary considerations. At present, the doctor in civilian practice is assured earnings far beyond those of the Army officer. The specialists earn two and three times, and many earn ten times, as much in civilian practice as they would receive in pay and allowances as army officers. The medical officer is at a disadvantage in terms of earnings, and some other factors, in comparison to the Veterans Administration doctor. Even within the Army he would be considerably ahead in earnings if, upon graduation from college, he chose the career of a line officer rather than spend 5 years in medical school and internship to qualify for a commission in the Medical Corps. Titles I and II of the proposed bill seek to take these facts into account. They attempt to compensate the Army doctor for the extra cost of his education and to narrow the gap between his pay and the income of the civilian doctor. On the basis of studies we have made, we know that many young men would consider coming into the Army if their incomes were raised.

I have great hopes that the professional and financial titles of the bill will help solve the acute phases of our procurement problem but I believe it would be false optimism to think that they will solve it completely. That is why I consider title V so important. It is actually emergency legislation which we will use to the extent that we fail to obtain sufficient doctors for the Medical Corps.

I can assure you that all the members of the corps will do their best in the future, as they have in the past, to provide the highest quality of medical service to the soldier at home and abroad. But a medical service needs not only adequate numbers of doctors but doctors who are properly qualified. I believe that this bill is essential in helping the Army to obtain the needed doctors and in retaining those that we now have.

STATEMENT OF BRIG. GEN. GUY B. DENIT, DEPUTY FOR PLANS,  
OFFICE OF THE SURGEON GENERAL

General DENIT. Mr. Chairman, our charts represent very much the same situation that Admiral Swanson's charts represent. The House is on fire. He has been turning the hose on it from one side of the house, and I want to turn it on from the other side, just to explain the Army situation.

I think this first chart here represents more clearly than anything I can say the importance of the medical service to an army. Here, in the Mexican War, we had 140 deaths for every 1,000 men in the Army during a year's time, that is, death from disease. In World War I we had 16.5 per thousand per year. In World War II that figure got down to the phenomenal figure of six-tenths of one man per thousand per year dying on account of disease. Certainly this chart shows more clearly than anything I can say the recognition of the importance of a good medical service to the Army.

Our situation in the Army with reference to personnel is shown in this chart. The Regular Army is shown here in black. These figures here are in black because they are black. This says 1,100. As a matter of fact, we don't have 1,100 now. The resignations are still continuing to come in, plus our retirements. A great many of our people now have had 30 years service. For an Army, as General Eisenhower told you, of 1,000,000 men we need 6,000 doctors. That means that we are going to be 1,500 doctors short in June 1947; 1,500 doctors short in June, 1948; and 3,700 doctors short in 1949. If the war is suddenly declared off, all of these people, who are in forced labor, more or less, will no longer be obligated to the Government. That leaves us in the Regular Army, then, with 1,100, to meet a requirement of 6,000, which gives us 4,900 short for a million-man Army, and 3,900 short if we have an Army of 875,000, if we get down that low. That is the situation with regard to the Medical Corps of the Army today.

In order to meet that situation, we did everything humanly possible to interest these young men, and the older ones. We had as many as 47,000 doctors in the Army. We had these two integrations. We were attempting to interest them in the Army as a career. We got only 852 applications, to meet a requirement of 2,062. Out of that total, we took in 218. So, we ended up, in those integrations, 127 officers short of what we had when we started, because we had a lot of resignations and retirements. We had this big program in order to interest them to come in the Army, and we ended up exactly with 127 short of what we had when World War I started.

Now, just to show the difference between the popularity of the medical service and the rest of the Army, they got 100,000 applications to fulfill a requirements of 20,000 officers, or five applications for every vacancy. On the other hand, we got those 852—as a matter of fact, we only got about 600 and some down from the Adjutant General's Office, because the other 200 never met the requirements, so our boys never saw them, but be that as it may, we had one application for three vacancies, whereas the rest of the Army had five applications for every vacancy. That shows you the popularity of the Medical Department of the Army, how we came out in the popularity contest.

We didn't come out very good in the popularity contest.

I don't believe it is necessary for me to go all over the pay scale again, because I have placed it there before you gentlemen. It is graphically shown in this chart. It shows the situation in comparison to the Veterans' Administration. It is extremely interesting to know that a young boy out of school, with less than 3 years service, can now get \$5,600 a year. There is a little chap that I know who went out to the coal mines in West Virginia last month. He hadn't even had his internship and his diploma hadn't been passed on. They gave that boy \$750 month. The coal company paid that. So far as I know, he hasn't even gotten his license. There is no use in comparing that, because I have placed that in front of you gentlemen there.

Now, as to this pay situation, this chart shows graphically the difference in pay between two young men starting out from college. We are not taking into consideration any West Point factor, or the Government paying the education. We are starting two young men out from college, both of them having graduated from the same university. One of them elects to come into the Army through the ROTC and the other elects to come in through the medical route. He ends up, as we have shown, and as Admiral Swanson's charts have shown, with \$26,000 short, but over an extended period of time, if we give any consideration as to the use of money over that time, the actual difference is \$52,976.

May I say to you, please, Mr. Gavin, I enjoyed seeing those little pamphlets. It is quite amazing. Here is a captain in the Army that is offered less pay than we are offering a dietitian who tells us to eat carrots and spinach. That is an actual fact. Here are the pay scales for the P grades in the various offices throughout the Government service. Here is the highest pay that the Army officer can get, unless he happens to be a major general. The pay of a brigadier general and a colonel are the same. I have given you gentlemen those charts. I hope that you will have a chance to study them.

General BLISS. Thank you, General.

If you care to ask any questions now, I will be very pleased to answer any.

Mr. BLACKNEY. Any questions?

Mr. HÉBERT. Mr. Chairman, I just want to ask the General, for the record, the same question I have asked every other witness, in connection with the advisability and desirability of establishing a medical school for the armed services.

General BLISS. I think it should receive the most careful study. I have been thinking carefully about it for the last 30 years and been interested in it. It should be given the most careful consideration and study by every agency.

Mr. HÉBERT. Thank you, General.

Mr. BLACKNEY. General, have you any data with reference to the dental shortage?

General BLISS. Yes; we have three corps: The medical, dental, and veterinary. They are all in short supply. We attempted to bring our corps up to the organized strength of 3,000. You have heard the figure 6,000 given. We are authorizing 3,000 doctors in the Regular Army. Our goal was to get 2,073 in the Medical Corps. We had

679 applicants. There were 852, but many were thrown out. We ended up, if everything comes in—and only the day before yesterday some of these applications have gone to the men and we don't know that they will accept—if we get all the last ones, minus 53 in the Medical Corps. In the Dental Corps we attempted to fill our authorized strength of 720. Our procurement goal is 506. For those 506 we had 494 applicants. When we get through in our Dental Corps, we will have 107 plus over what we had before. In the Veterinary Corps, if you are interested in that, we had 87 as our procurement goal and we will end up plus 59. These are the comparative figures on that. In the Dental Corps, we had, as I say, 494 applicants for 506 positions, and in the Medical Corps, 629 for 2,073.

Mr. BLACKNEY. Any further questions?

(No response.)

We thank you, Doctor.

General BLISS. Thank you.

Mr. BLACKNEY. The committee will adjourn until tomorrow morning at 10 o'clock.

**HOUSE OF REPRESENTATIVES,  
COMMITTEE ON ARMED SERVICES,  
SUBCOMMITTEE NO. 10, PAY AND ADMINISTRATION,**

*Friday, June 6, 1947.*

The subcommittee met at 10 a. m., Hon. William W. Blackney (chairman) presiding.

Mr. BLACKNEY. The committee will resume its hearings on H. R. 3174, the Army bill, and H. R. 3254, the Navy bill.

Mr. BLANDFORD. Mr. Chairman, I have received two communications, one from the Army and one from the Navy, pertaining to the shortage of doctors and dentists, with a statistical break-down. I ask that they be inserted in the record at this time.

Mr. BLACKNEY. Without objection, they may be inserted in the record.

(The material is as follows:)

**STATEMENT OF MAJ. GEN. R. W. BLISS, THE SURGEON GENERAL,  
UNITED STATES ARMY**

The dental picture in the Army is not too bright from a procurement standpoint. However, we were more fortunate in the integration of dentists in the Army than doctors, but we did not fill our 720 authorized strength for the Regular Army Dental Corps. In contrast to the integration experience of the Medical Corps where there was only one application for every three vacancies, the Dental Corps had a little better than one application for every vacancy in that corps. At the beginning of the intergration we had in the Regular Arny Dental Corps 469 vacancies and there were 494 applications for these vacancies. It is anticipated that at the end of the integration this year there will be approximately 450 dentists in the Regular Army leaving a shortage in the authorized strength of 270 dentists. However, this is but a part of the picture since in addition to the 720 authorized for the Regular Army we require approximately 1,500 additional dentists to meet the needs for the interim Army of 1,070,000. These additional dentists will of necessity have to come from the Dental Reserve Corps or be employed by contract. At present we have a strength of 1,650 dentists. However, when their required period of service expires only the Regular Army Dental Corps and such Reserve officers as volunteer for extended active duty will be available to serve the needs of the Army.

Recommendations with regard to the dental problem are being reviewed by the War Department and other interested agencies at the present time. However,

it was felt that the War Department could not delay the legislation with reference to the Medical Corps until the completion of the study of the Dental Corps situation. The report of the Medical Advisory Committee of the Secretary of War dealt only with the problem of the Medical Corps. There was complete unanimity of opinion with regard to the Medical Corps bill throughout the War Department and the other agencies whose concurrences were essential in presenting the recommendations to Congress. That is why the present five-point bill now being considered pertains only to physicians and surgeons.

DEPARTMENT OF THE NAVY,  
BUREAU OF MEDICINE AND SURGERY,  
*Washington 25, D. C., June 6, 1947.*

Hon. WILLIAM W. BLACKNEY,

*House of Representatives, Washington, D. C.*

DEAR CONGRESSMAN BLACKNEY: This Bureau appreciated the opportunity of presenting to your committee various factors of the acute medical officer personnel shortage.

In accordance with your request, I am forwarding herewith a set of tables showing the full and complete picture of the dental officer situation for your perusal and inclusion in the record as you may desire.

In order to allow a thorough comparison of the situations by your committee, I am also forwarding a similar set of tables for the medical officer personnel expectancy.

I trust that this information will meet your needs and if I can furnish any additional data, please do not hesitate to call upon me.

Very sincerely yours,

C. A. SWANSON,  
*Rear Admiral (MC) U. S. N., Chief of Bureau.*

TABLE I.—*Present and estimated future dental officer personnel strength U. S. Navy*

	May 1, 1947		July 1, 1947		July 1, 1948		July 1, 1949	
	Number	Percent	Number	Percent	Number	Percent	Number	Percent
Authorized.....	1,320		1,320		1,320		1,320	
Appropriated.....	1,320	100	1,169	100	1,164	100	924	100
U. S. Naval Reserve.....	68		53	{ 20 }	0		0	
V-12 and ASTP (involuntary)	645	53	613	54	396	34	50	5
U. S. Navy.....	524	40	524	45	514	44	499	54
Total on board.....	1,237		1,157		910		549	
Deficiency.....	93	7	12	1	254	22	375	41

TABLE II.—*Deficiency of USN dental officers below estimated appropriated strength*

	May 1, 1947	July 1, 1942	July 1, 1948	July 1, 1949
Number deficient.....	796	645	650	425
Percent of appropriated strength.....	60	55	44	54

TABLE III.—*Ratios of available billets, applications and acceptances for dental officer commissions*

Billets.....	797.	
Applications.....	330	41 percent of billets available.
Acceptances.....	117	16 percent of billets available.

TABLE IV.—*Resignations USN Dental Corps from 8-15-45 to 5-1-47*

124 resignations or 24 percent of the 523 United States Navy dental officers on board on VJ-day.

TABLE V

Resignations (124) are equal to 106 percent of acceptances (117) since VJ-day.

TABLE I.—*Present and estimated future medical officer personnel strength, U. S. Navy*

	May 1, 1947		July 1, 1947		July 1, 1948		July 1, 1949	
	Personnel	Percent	Personnel	Percent	Personnel	Percent	Personnel	Percent
Authorized.....	4,315		4,315		4,315		4,315	
Appropriated.....	4,315	100	3,798	100	3,781	100	3,000	100
USNR.....	176		106		0		0	
V-12 (involuntary).....	1,399	37	1,674	47	1,100	30	0	
Ret.....	13		13		13		0	
USN.....	1,672	39	1,244	33	1,150	30	1,050	35
Total on board.....	3,260		3,037		2,263		1,050	
Deficiency.....	1,055	24	761	20	1,518	40	1,950	65

Exclusive of 476 medical officers on duty with the VA and PHS.

TABLE II.—*Deficiency of U. S. N. Medical Officers below estimated appropriated strength*

	May 1, 1947	July 1, 1947	July 1, 1948	July 1, 1949
Number deficient.....	2,643	2,554	2,631	1,950
Percent of appropriated strength.....	61	67	70	65

TABLE III.—*Ratios of available billets, applications and acceptances for medical officer commissions*

Billets.....	2,845	
Applications.....	458	16 percent of billets available.
Acceptances.....	217	8 percent of billets available.

TABLE IV.—*Resignations U. S. Navy Medical Corps from Aug. 15, 1945, to May 1, 1947*

864 resignations or 44 percent of the 1949 U. S. Navy medical officers on board on VJ-day.

TABLE V

Resignations (864) are equal to 398 percent of acceptances (217) since VJ-day..

Mr. BLACKNEY. Dr. Crabtree.

Dr. CRABTREE. Mr. Chairman—

Mr. BLACKNEY. Give your name and position to the stenographer.

Dr. CRABTREE. For the record, my name is Dr. James A. Crabtree. I am Deputy Surgeon General of the United States Public Health Service. I have a prepared statement, and also a short statement.

from the Administrator of the Federal Security Agency, which with your permission I should like to submit for the record.

Mr. BLACKNEY. Very well.

(The statements are as follows:)

STATEMENT OF DR. JAMES A. CRABTREE, DEPUTY SURGEON GENERAL, UNITED STATES PUBLIC HEALTH SERVICE, BEFORE THE SUBCOMMITTEE ON PAY AND ADMINISTRATION OF THE ARMED SERVICES COMMITTEE

Mr. Chairman and members of the committee, enactment of legislation which will promote the recruitment of physicians to the career services of Government is of the utmost importance to the Public Health Service. Like the Army and Navy, the Public Health Service has been unable to compete with opportunities offered in private practice, in universities, industry, and the Veterans' Administration.

I am sure that the committee is aware of the tremendous increase in the responsibilities placed upon the Service during recent years. The last Congress added substantially to our duties in the Hospital Survey and Construction Act, the National Mental Health Act, the Federal Employees Health Service Act, and by the increased funds appropriated for research grants and grants to the States.

Such expansion of responsibility obviously requires a strengthening of our manpower. Instead, we are faced with a steady depletion of our medical ranks.

We need 1,500 medical officers to carry on the present work of the Public Health Service. Our authorized Regular Corps strength for the current fiscal year is 697, but we began the year on July 1, 1946, with only 590 physicians in the Regular Corps. These were supplemented with 614 Reserve Corps medical officers, composed of two groups: 114 former ASTP officers who had been released by the Army to serve out their time in the Public Health Service, and 500 others, most of whom had entered this Service for the duration and were looking forward to early release. Thus our total strength was 1,204, or at least 20 percent short of our needs.

By April 30 of this year, the number had dropped from 1,204 to 899, or 60 percent of needed strength in spite of the assignment by the Navy of 75 V-12 medical officers obligated to serve for 2 years. In spite of intensive recruitment efforts, the Regular Corps strength had dropped from 590 to 522 as a result of 120 resignations, 5 retirements and recruitment of only 59. The Reserve strength had dropped from 614 to 302 through separations by request. Of those Reserves who remained on active duty, 130 were ASTP's who, with the 75 Navy medical officers on detail, were serving under compulsion. All but 30 of these will be eligible for release at their own request within 15 months. Only 14 of the more than 200 ASTP's and V-12's now on duty with or detailed to the Public Health Service have qualified for the Regular Corps.

Most serious is the fact that 114 of the Regular Corps medical officers who have resigned since July 1, 1946, were in the permanent grades of captain or major—men with 3 to 15 years' training and experience. The types of service required of our organization make it imperative that we rely on this group for a large part of our work.

It is often overlooked that, in addition to the better known programs of the Service, there is a vast range in the duties which Public Health Service officers are called upon to perform. Our physicians serve with the Coast Guard, in the marine hospitals, with State and local health departments and on quarantine stations. Public Health Service officers are detailed to positions of high responsibility in other Federal agencies such as the State Department, the Department of Agriculture, and the Maritime Commission. They provide medical care in Federal prisons and are responsible for the examination of immigrants at foreign ports. Our men are attached to American Consulates and Embassies in Europe and in the Orient. Public Health Service officers are staffing a mission in Liberia. We have physicians on detail to the Philippine Government. We are now being called upon to supply medical staff for the United States Mission to Greece.

These functions require seasoned officers with wide experience—the very men we are unable to retain because of low rates of pay and an unduly long promotion schedule. Not only is the Government losing their servicees, but it is losing the investment which it has made in their training and development.

Frankly, we in the Public Health Service see no relief from the situation unless means are advanced to meet the competition for physicians. Opportunities both in practice and in salaried positions outside the Service at two or three times

their present incomes are not unusual among our officers today. There is no need to dwell upon the existing Nation-wide doctor shortage. In such a market of scarcity, recruitment will become increasingly difficult, and resignations increasingly more common. To the extent that the national shortage continuously diminishes the number of physicians available for recruitment and continuously threatens our present ranks, it poses a permanent problem for the Public Health Service.

Liberalization of the pay scale would constitute a major step toward solution. Public Health Service officers under the authority of the Pay Readjustment Act of 1942 receive the same pay and allowances as officers of comparable grades in the Army, Navy, Coast Guard, and Coast and Geodetic Survey. It is only equitable, therefore, that the provisions of titles I and II of H. R. 3174 be extended to include medical officers of the Public Health Service.

While the Administrator of the Federal Security Agency has endorsed the provisions of H. R. 3174, I would like to point out that H. R. 3254 more fully meets the needs of the Public Health Service regarding the certification of specialists. H. R. 3174 would limit the designation of specialists, at present, entirely to clinical fields. The broader certification authority contained in H. R. 3254 would permit the designation of specialists in fields of research and public health to which the Public Health Service must turn for many of its skilled personnel.

In order to avoid inconsistency, it also is suggested that a new title VI be added to these bills to amend section 209 (b) of the Public Health Service Act. Section 209 (b) now provides that Reserve officers on active duty shall receive the same pay as officers of the Regular corps. This provision should be made consistent with sections 101 of H. R. 3254 and H. R. 3174 which stipulate that only those Reserve officers who volunteer and are accepted for extended active duty of 1 year or longer shall be eligible for the increase in pay.

I have discussed only those sections of H. R. 3174 and 3254 which are applicable to the Public Health Service. Other adjustments in our personnel policies requiring legislation will be sought through amendments to the Public Health Service Act (Public Law 410, 78th Cong.). Titles I and II of H. R. 3174 or 3254, if amended to apply to the Public Health Service and enacted, however, will have great and beneficial effect on the recruitment of Public Health Service officers. I urge, therefore, that you give favorable consideration to the proposed amendments and to the bills before you.

**STATEMENT OF WATSON B. MILLER, FEDERAL SECURITY ADMINISTRATOR, FOR  
SUBCOMMITTEE ON PAY AND ADMINISTRATION OF THE ARMED SERVICES  
COMMITTEE**

The steadily increasing shortage of physicians in the Public Health Service is a matter of great concern to me. The steady growth in our knowledge of health techniques received special impetus during the war and has been reflected in continued expansion of the responsibilities placed upon the Service by the people of the United States through their representatives, the Congress. This trend was manifested last year by three entirely new laws, the Hospital Survey and Construction Act, the National Mental Health Act, and the Federal Employees' Health Service Act. It has been emphasized further by the steady expansion of funds for grants to States and for research.

The Public Health Service is faced with the necessity of meeting these increased responsibilities with a decreasing medical staff. During the 9 months ending June 30, 1947, separations of medical officers were more than twice the number of new appointments. At the present rates of pay, the Service cannot successfully compete with the private practice of medicine.

I should like to urge that the committee give favorable consideration to H. R. 3174, amended to include the Public Health Service, as recommended in our letter of May 8.

Dr. CRABTREE. While I am here, I would merely like to make some additional remarks from notes.

Mr. BLACKNEY. Very well.

Dr. CRABTREE. In view of the fact, Mr. Chairman, that normally legislation pertaining to the Public Health Service comes under the cognizance of other committees of the Congress, I thought it might

be well for purposes of the record to review briefly just who we are and why we are here.

The Public Health Service, as you may know, has contained a commissioned corps of officers—medical, dental, pharmacy, and other health specialties—since 1879. Commissioned officers of the Public Health Service, under provisions of the Pay Readjustment Act of 1942, receive the same pay and allowances as officers of corresponding grade in the Army, Navy, Coast Guard, and Coast and Geodetic Survey. The rates of promotion of commissioned officers of the service are by law the same as those applicable to the Medical Department of the Army.

For these reasons, therefore, we believe it would be only equitable that such provisions of titles I and II of the bills before you as may be adopted be made also to apply to commissioned officers of the Public Health Service.

I should like, too, to enumerate briefly some of the functions of the Public Health Service. We operate 27 hospitals, one of which is for the special treatment of leprosy, two for the treatment of drug addiction, one for the special treatment of tuberculosis. We operate hospitals and medical installations at all Federal prisons. We provide medical and hospital care for the Coast Guard. Similarly we provide medical and hospital care for the merchant marine. We direct the health and medical-care programs for the Indians, in the Indian Bureau of the Department of the Interior. We provide medical and hospital care for all beneficiaries of the Federal Employees' Compensation Act. We operate quarantine stations at all principal ports of entry in this country, both of ships and airplanes, for the purpose of preventing the introduction in this country of disease from abroad. We have medical officers stationed at all of the principal American embassies and consulates abroad, for purposes of examining and certifying to the health status of prospective immigrants into this country. One of the major activities of the Public Health Service over the last 50 years has been in the field of research. Out at Bethesda, in our National Institute of Health, and in the field laboratories stationed in various parts of the country, we are engaged in a very elaborate and substantial program of research in the various specialties of health and medicine. We are responsible for licensing all manufacturers of biological products—vaccines, serums, and the like—that enter into interstate commerce. Our licensing is for the purpose of certifying to the safety, purity, and potency of all such products. Then, too, we provide special consultation services to the health organizations of State and local governments, not only in the general field of public health but in such special problems as malaria, tuberculosis, venereal disease, cancer, dental health, mental health, hospital construction, communicable-disease control, et cetera. These are our more traditional and more routine responsibilities.

In addition, Mr. Chairman, there is hardly a department of the Federal Government that does not have, in connection with its major responsibilities, some incidental health problems, health programs that arise incidentally to their major operations. In that connection, it is the rule rather than the exception, when the head of the department so concerned does not request the Public Health Service to manage and operate the health phases of such programs. In that regard, we have medical and dental officers, sanitary engineers, and

other personnel assigned to such departments as the Department of the Interior, the Department of Agriculture, the Department of State, the Maritime Commission, the Department of Justice, the Employees' Compensation program, the vocational-rehabilitation work, the Pan American Sanitary Bureau, and traditionally over the years the War and Navy Departments. In addition, we are operating a special health mission in Liberia. Medical officers are attached at the moment to the Philippine Government. Our most recent responsibility is one in connection with the health phases of what is about to be created, the mission to Greece, under the aid program authorized by the present Congress within the last few weeks.

I cite these things, Mr. Chairman, to indicate the broad diversity of the problems that engage the attention of the Public Health Service and to indicate, moreover, the highly specialized character of many of them. It is through the mobility of our personnel, that is inherent in the commissioned corps principle that has made it possible for us in the Public Health Service in the past, with a relatively small corps, to cope with such widely diversified problems. During the war we were able in the Service to meet our needs reasonably well, simply because of the patriotic impulses of civilian physicians, dentists, engineers, and other personnel; but since the war, Mr. Chairman, our situation in the Service is peculiarly critical. We have shared the experience of the Army and Navy in losing personnel on the one hand, but we are in the peculiar position of having increasing responsibilities placed upon us on the other, so that instead of our obligations decreasing they are now increasing. For example, the last Congress gave to the Public Health Service three new major action programs, through the enactment of the Hospital Survey and Construction Act, the National Mental Health Act, and the Federal Employees' Health Services Act. In addition, substantial increases in appropriations were made to the Public Health Service for its work particularly in cancer and in general health work, so that whereas I have no charts or maps, Mr. Chairman, to present to you, our situation is no less critical.

In my prepared statement are some statistics. I should like to merely review them here briefly. When we take into account the total needs of the Public Health Service at present for medical and dental officers in both Reserve and Regular corps, we find that as of this moment we have a 40 percent deficit in medical officers. We have practically a 50 percent deficit in dental officers. I make this statement because apparently our experience with dental officers may not be entirely similar to that of the Army or Navy.

In respect to the Regular corps, there our deficit can be stated only in terms of authorized strength. As of the moment, in relation to the number of Regular corps officers authorized, we have a 25-percent deficit in medical officers Regular corps and almost exactly the same deficit in the case of dental officers. In the case of the authorized strength in the Regular corps that is anticipated for next fiscal year on the one hand and the responsibilities as we now see them of recruitments during the next few months, we face 1948 with this situation: In the case of the Regular corps, for every three officers authorized we will have one vacancy and for every four dental officers authorized in the Regular corps we anticipate one vacancy.

Mr. Chairman, during the war we had authority to make temporary promotions of our commissioned officers, and we took advantage of that authority. It was through those temporary promotions that we were enabled to hold many of our people, that we otherwise certainly would have lost during the period following the cessation of hostilities. If the war should officially end and if in the meantime we should not have been able to obtain some liberalization of our present personnel policy, we believe that we would lose an additional 15 to 35 percent of our present strength of medical and dental officers, and as an inevitable consequence of that I am sure the Public Health Service would be forced to default in some of its obligations.

Title III, IV, and V of the legislation before you are we believe enabling legislation and for that reason we would not recommend that those titles be amended, from the point of view of the Public Health Service. To the extent that such provisions of those three titles might be appropriate for the Public Health Service, we would recommend that they be considered in separate legislation pertaining to the basic Public Health Service Act.

We would urge, however, that titles I and II of the bills before you be amended to include officers of the Public Health Service and that as amended they be enacted at the earliest practicable date.

In connection with title II, Mr. Chairman, we believe that the Navy version of title II is far better adapted to the needs of the Public Health Service. Title II of the Army bill is so worded that the specialists covered in that title would be limited to the so-called clinical fields. The wording in the Navy bill is somewhat more flexible and would permit of the designation of specialists in fields of research and in public health, both fields being those on which the Public Health Service relies very heavily, indeed, for a substantial number of its people.

Thank you very much, Mr. Chairman.

Mr. BLACKNEY. Thank you, Doctor, for your statement. The Public Health Service has a very diversified functions, hasn't it?

Dr. CRABTREE. That is right, Mr. Chairman. As I say, I cited them here in view of the fact that this committee normally has very little to do with us.

Mr. BLACKNEY. Doctor, in the statement that I have, you say that the beneficiaries under the Public Health Service for dental care, treatment, and so on, number 256,000. Is that a correct statement?

Dr. CRABTREE. That is substantially correct, Mr. Chairman. The Coast Guard, the merchant marine, and all civil employees of the Federal Government who may become ill or injured in line of duty, under the provisions of the Employees' Compensation Act would be the three major categories of beneficiaries. There are several other minor ones.

Mr. BLACKNEY. What is your total doctor staff in the Public Health Service now? Also give us your dental staff.

Dr. CRABTREE. I believe, Mr. Chairman, you will find on the first page of my statement that we had 590 physicians in the Regular corps and 614 in the Reserve Corps as of July 1, 1946, or a total of 1,412. By April 30 of this year that number has dropped from 1,204 to 899.

Mr. BLACKNEY. Then, your department has a serious problem with reference to keeping suitable dental and medical personnel?

Dr. CRABTREE. We do, indeed, Mr. Chairman. I can say honestly that it is causing us more concern than any other single problem at the moment, in the Public Health Service.

Mr. BLACKNEY. Do I understand your department, then, would favor titles I and II?

Dr. CRABTREE. We—

Mr. BLACKNEY. Bringing the Public Health Service within the purview of those provisions?

Dr. CRABTREE. We not only would favor it, we would urge it.

Mr. BLACKNEY. Yes.

Dr. CRABTREE. And I might say, if titles I and II should be enacted to apply only to the Army and Navy, leaving us out of the picture, it would be tragic.

Mr. BLANDFORD. I have some questions, Mr. Chairman.

Mr. BLACKNEY. Mr. Blandford.

Mr. BLANDFORD. Dr. Crabtree, would you amend titles I and II to say "officers of the Public Health Service" or would you amend it to say "doctors and dentists of the Public Health Service"?

Dr. CRABTREE. The same categories. If, for example, the committee sees fit to recommend that titles I and II be confined to medical officers, then, obviously, it would be appropriate to refer only to medical officers of the Public Health Service. If it should see fit to include also dental officers—which, incidentally we would recommend—then use the same categories.

Mr. BLANDFORD. My point in asking is what do you have beside doctors and dentists among your officers in the Public Health Service?

Dr. CRABTREE. We have in the Public Health Service officers representing categories of training and experience that cover every aspect of public health. We have physicians, dentists, nurses, sanitary engineers, a wide variety of scientists, including physicists, bio-chemists, entomologists—covering practically every basic scientific field in medicine.

Mr. BLANDFORD. The statistics that you gave us are confined to doctors?

Dr. CRABTREE. Only physicians and dentists.

Mr. BLANDFORD. I see. What would be the added cost if we included, first of all, doctors in this bill, and, secondly, if we included doctors and dentists.

Dr. CRABTREE. I have some figures here, Mr. Blandford, that would show the costs for doctors. The cost of title I under the present situation would amount to \$1,156,800 annually. The cost of title II under the Army bill, which is limited to specialists in the clinical fields, would amount to \$42,750 for the Public Health Service. If the Navy version of title II should be enacted, I would not be able at the moment to suggest the cost because we don't have the information immediately at hand as to how many of our officers would qualify under a broader form of certification.

Mr. BLANDFORD. But it would be in excess of \$42,000.

Dr. CRABTREE. It would be in excess of \$42,750. Unfortunately I don't have the figures before me in respect to dentists. I would be very glad to submit them for the record.

Mr. BLANDFORD. I am informed that it would be approximately a quarter of a million dollars.

Dr. CRABTREE. Perhaps that is correct. I don't have the figures in front of me.

Mr. BLANDFORD. Thank you very much.

Mr. BLACKNEY. Mr. Shafer, have you any questions?

Mr. SHAFER. No.

Mr. BLACKNEY. Mr. Hébert.

Mr. HÉBERT. Doctor, do you have any difficulty in recruiting for your other fields in the Public Health Service, outside of physicians and dentists?

Dr. CRABTREE. Except for physicians and dentists, Mr. Hebert, we are in reasonably comfortable circumstances. There are some categories in which we have more applicants than job opportunities.

Mr. HÉBERT. That is all, Mr. Chairman.

Mr. BLACKNEY. Thank you, Doctor.

Dr. CRABTREE. Thank you very much.

Mr. BLACKNEY. Dr. Metz, of the American Dental Association.

Dr. METZ. Yes, sir.

Mr. BLACKNEY. Doctor, will you give your full name and title to the stenographer, please.

Dr. METZ. Dr. Karl H. Metz.

Mr. Chairman and members of the committee—may I be seated?

Mr. BLACKNEY. Yes. You may proceed.

#### **STATEMENT OF DR. KARL H. METZ, APPEARING ON BEHALF OF DR. CARL O. FLAGSTAD, CHAIRMAN OF THE COMMITTEE ON LEGISLATION, AMERICAN DENTAL ASSOCIATION.**

Dr. METZ. My name is Dr. Karl H. Metz. I have been engaged in the practice of dentistry in the city of White Plains, New York, for the past 27 years approximately, except for a continuous period of 5½ years I served in the armed forces, with extended active duty in the continental United States, including the Dental Division of the Surgeon General's Office, U. S. Army, and in the European-African-Middle East theaters of operations. I served for approximately 3 years overseas in the following capacities: Dental officer, Staff; Dental consultant; Chief of Dental Service; executive officer, Medical Section, Production Control Agency, G-4 Division, SHAEF, attaining the rank of colonel, Dental Corps, AUS as of April 3, 1945, in France.

Since May 1, 1946, approximately, I have been a member of the advisory committee to the Veterans' Administration for the Dental Society of the State of New York, and have likewise served as chairman of the veterans' guidance committee, or military affairs committee, of the same society, a component of the American Dental Association.

I hold currently, a commission as colonel, Dental Reserve Corps, U. S. Army, and will complete 30 years of service (active- and inactive-duty status) on November 20, 1947. Active duty has been had both in World War I and World War II, as well as peacetime service in the interval between both wars.

I am presenting this statement on behalf of Dr. Carl O. Flagstad, chairman of the committee on legislation, American Dental Association.

The American Dental Association wishes to support H. R. 3174 and H. R. 3254, which will grant medical officers in the Army and Navy additional remuneration. The services of the medical officers are

absolutely essential to the health welfare of the armed services. Therefore, it is highly important that adequate corps of medical officers are continually on duty with the Army and the Navy. Since the problem of retaining qualified medical officers in the service and in securing additional officers to fill existing vacancies has become extremely acute, this legislation should be enacted to help solve the problem. The American Dental Association, cognizant of the medical officers' importance to the military services, emphatically endorses immediate enactment of these bills.

However, we desire to call the Armed Services Committee's attention to the fact that a similar situation exists in the Dental Corps in the armed forces. The heavy cost of a dental education in time and money, together with the demand for dental service in civilian life, makes it unremunerative for dentists to enter on a permanent career in any of the armed services. A comparison of the present salaries of dental officers, especially those in the lower ranks, with incomes earned in private practice indicates the selection of a career in the Army and Navy Dental Corps is unattractive.

It has proved to be impossible, under existing conditions, to retain and to procure dental officers for regular active service in the Navy in sufficient number to provide necessary dental care for the naval personnel. An effort was made last year to fill over 700 Naval Dental Corps vacancies through transfer of Reserve officers and by new appointments from civilian dentists to the corps. Only one vacancy was filled from the latter source. The number obtained by transfer of Reserve officers was insufficient to compensate for losses by resignation. The prospect this year is even less encouraging. More than one-half of the dental officers on active duty are reserves. Upon termination of the national emergency or at completion of their specified length of service, all Reserve officers being retained involuntarily must be released. The Navy Dental Corps then may have less than one-half the number necessary to meet requirements. A more critical situation exists in regard to the Army Dental Corps. The requirements for dental officers for the Army for 1947 and 1948 are 2,000. As of March 31, 1947, the number on duty was 2,000. This will be reduced to 1,500 by December 31, 1947, and by September 30, 1948, the total number on duty will be only 550, making a shortage of nearly 1,500, unless some additional inducement is provided to insure a larger number of applicants. Under present conditions, the Army has made urgent appeals to young graduates of dental schools to accept commissions without any appreciable results. As an example of how critical it is to obtain dentists, when replacements were necessary after VJ-day, Selective Service for the first time in history, at the request of the War and Navy Departments, used all of its persuasive measures in an effort to induce 1,500 dentists to enter the service. Only 900 were secured. The Navy, although short of dental officers itself, at that time loaned 800 to the Army. When the 2-year period of time for these officers and others have expired, the Army will be in a most difficult situation.

On the average, the cost of a dental education is greater than the average cost of other professions. The tuition fee for dentistry, as in medicine, averages higher than for other professions, and, in addition, the dental student must purchase an expensive set of dental instru-

ments. The student is also required to purchase textbooks and supplies for use while in school.

The minimum requirements for entrance into a dental or medical school is 2 years of predental or premedical education. However, a majority of students in both dental and medical schools have had more preprofessional years in college than the minimum requirements. Graduates of medical and dental schools can secure their internship in the armed forces with full pay and allowances as commissioned officers. This means that in such instances both dentists and physicians who have had a full 4-year course of preprofessional schooling have each had 9 years of training at the completion of their internship.

The Dental Corps of the Army and Navy are an integral part of the Medical Department with the Surgeon General, a physician, as chief and director of the department or bureau. It has always been the opinion of the various Surgeons General that medicine and dentistry operate most efficiently as a single unit in rendering health service in the armed forces. The salary scale for medical and dental officers in like rank has always been the same. The American Dental Association is concerned that any disparity in salaries between the two corps will be detrimental to the maintenance of an efficient and adequate Dental Corps.

The compensation offered by an Army or Naval career, as compared with the income available in civilian life, is one of the principal factors which influence potential candidates against accepting appointment in the Dental Corps. It is, therefore, imperative that inducements be offered to avoid further losses from the active-duty ranks and to attract candidates from civilian sources in sufficient number to bring the Dental Corps up to required strength at the earliest possible time.

Increase of dental officer's pay by \$100 per month undoubtedly would be an effective step toward maintaining a satisfactory dental service in the Army and Navy. Experience clearly indicates that without such an inducement it will be difficult to secure dentists to adopt careers in the Dental Corps, and consequently the important health services provided by members of this corps will be very seriously impaired.

The American Dental Association, motivated by its concern for the dental health of all American citizens, respectfully requests that increased compensation be provided for officers of the Dental Corps of the Army and Navy through appropriate amendment and enactment of H. R. 3174 and H. R. 3254.

Information received from the United States Public Health Service indicates that the situation respecting the Dental and Medical Corps in that Service is likewise critical, and the association is of the opinion that appropriate measures should be taken by the Congress to assure like treatment to medical and dental officers in that Service.

We have included on this prepared statement a list of suggested amendments to title I of H. R. 3174 and title I of H. R. 3254 which we offer for your consideration.

Mr. BLACKNEY. Thank you, Doctor. That is a fine statement. Let me ask: What is the total membership of the American Dental Association, do you know?

Dr. METZ. The total membership of the American Dental Association at the present time, I believe, sir, is 61,000. There are 65,000 active dentists. There are approximately 78,000 dentists in the

United States and its possessions. Some of those may be on the retired list, and so on.

Mr. BLACKNEY. As I understood your statement, the educational qualification is practically the same in both dentistry and medicine.

Dr. METZ. That is correct, sir.

Mr. BLACKNEY. As to term of years, and so on.

Dr. METZ. That is right, sir.

Mr. BLACKNEY. What is the average number of patients a dentist can care for in a year? Have you any ratio established as between dentists and patients?

Dr. METZ. Well, I am not avoiding an answer on that, but that is rather a difficult question to answer, sir, because it depends entirely on the type of service that the dentist may be rendering. Dentistry in itself is divided into specialties, sir, and not all operations within the various specialties take the same amount of time.

Mr. BLACKNEY. I appreciate that.

Dr. METZ. It is difficult for me to answer that.

Mr. BLACKNEY. I ask that question predicated on a statement I have from the Public Health Service that a dentist could take efficient care of approximately 500 patients. That is in the Public Health Service and not in civilian life.

Mr. Shafer, have you any questions?

Mr. SHAFER. No questions.

Mr. BLACKNEY. Mr. Gavin.

Mr. GAVIN. How many dentists are being graduated each year?

Dr. METZ. How many dentists are being graduated each year?

Mr. GAVIN. Yes.

Dr. METZ. About 2,250, I believe. Is that correct, Dr. Camalier?

Dr. CAMALIER. Yes, sir.

Dr. METZ. Two thousand two hundred and fifty dentists and about five thousand physicians.

Mr. GAVIN. Do you know how many boys are making application to study for the dental profession each year at our various universities?

Dr. METZ. I do not know the number throughout the United States at the various dental schools within the various universities.

I might cite, for instance, in George Washington University they have 600 applicants and they could only take 90 students.

Mr. GAVIN. That is exactly what I am trying to determine. It was stated here the other day there were 1,500 applications received by George Washington University and they could only accept 80, I believe. What are the figures you gave, again?

Dr. METZ. For dentists?

Mr. GAVIN. Yes.

Dr. METZ. Six hundred applicants and ninety actually could be accepted at George Washington University. In other words, they could accept but ninety.

Mr. GAVIN. Then, evidently the same situation applies to the dentists as to the doctors. Our school facilities evidently are not adequate to take care of the pupils who are ambitious and want to follow that profession.

Mr. BLACKNEY. Mr. Hébert?

Mr. HÉBERT. No questions.

Mr. BLACKNEY. Mr. Blandford?

Mr. BLANDFORD. I just want to ask the doctor, if you don't have specialists in the Dental Corps, the same as the doctors have.

Dr. METZ. We do have specialists; yes, sir.

Mr. BLANDFORD. How about title II, then, of the bill, insofar as specialists are concerned?

Dr. METZ. We are not interested in title II, sir.

Mr. BLANDFORD. Thank you; that is all.

Mr. BLACKNEY. If there are no further questions, we thank you, Doctor.

Dr. METZ. Thank you, sir.

Dr. CAMALIER. Thank you, gentlemen.

Mr. BLACKNEY. Dr. Robert M. Ashley, of the American Osteopathic Association—

Mr. GAVIN. I wonder, Mr. Chairman, before the Doctor testifies, if I could ask Dr. Metz another question while he is still here?

Dr. METZ. Yes, sir.

Mr. GAVIN. What is the American Dental Association doing to take care of these evident deficiencies we have in our educational system; that is, toward improving facilities to take care of additional students that are desirous of entering the profession?

Dr. METZ. May I ask the assistant secretary of the American Dental Association, Dr. Camalier, to answer that for you, please?

Mr. GAVIN. Yes.

Dr. CAMALIER. The association has been aware of that problem. The council on dental education has been urging the dental schools to increase their facilities. They have been getting more money from their State legislatures and from other sources. They are attempting to do it in that way. They are also urging the establishment of more dental schools in the United States. But it is a difficult situation at the present time.

Mr. GAVIN. Are you going to make a report on the matter after you complete this study that you say the association is now engaged in?

Dr. CAMALIER. Yes.

Mr. GAVIN. I would like to receive a copy of that report, to indicate what the association is doing to assist us in this program toward providing facilities to take care of those that are ambitious and want to continue their school work and follow the profession.

Dr. CAMALIER. I think that report will be made at the August meeting of the American Dental Association, to be held in Boston. We could be very glad to do that, sir.

Mr. HÉBERT. May I ask one question?

Mr. BLACKNEY. Yes.

Mr. HÉBERT. Is the tuition fee charged sufficient to cover the cost of the education of an individual student in a dental school?

Dr. CAMALIER. No; it is not. The average dental school has to depend upon its income from clinics, unless it is supported by the State. Usually they also depend upon that income.

Mr. HÉBERT. What would you say as a general rule, Doctor? What is the difference between the tuition and the actual cost of educating a dental student?

Dr. CAMALIER. I wouldn't like to say the exact figures there, but I know they depend—

Mr. HÉBERT. Just to give us an idea. Mr. Gavin suggested establishing new schools and the thought occurs to me, is it possible without

endowment or without legislative appropriation in the case of State schools? Dr. Morgan told us yesterday that at Vanderbilt there is a \$650 fee per year and it costs \$4,000 a year to educate the individual, so you see there is a difference of \$3,350.

Dr. CAMALIER. That is about the same thing for dentistry, except it costs a little more—

Dr. METZ. It costs more.

Dr. CAMALIER. To educate a dentist than it does a physician, because of the equipment that he must buy. I would say there is quite a disparity there. I wouldn't like to give the figures at this time. I can furnish those to the committee, however. I would be very glad to do that.

Mr. HÉBERT. All right.

Mr. BLACKNEY. I have a statement here, Doctor, that says the dental equipment would average from \$600 to \$1,000.

Dr. CAMALIER. That is true.

Mr. BLACKNEY. That would be your judgment?

Dr. CAMALIER. That is true.

Dr. METZ. Yes.

Mr. GAVIN. But the American Dental Association is giving very careful attention to that particular problem at this time.

Dr. CAMALIER. Absolutely; we certainly are.

Mr. BLACKNEY. Give your full name to the reporter, Doctor.

Dr. CAMALIER. Dr. C. Willard Camalier, secretary of the military affairs committee, American Dental Association.

Mr. BLACKNEY. Thank you, Doctor.

Now, Dr. Ashley.

#### STATEMENT BY DR. ROBERT M. ASHLEY, ON BEHALF OF THE AMERICAN OSTEOPATHIC ASSOCIATION

Dr. ASHLEY. Mr. Chairman and members of the committee, my name is Dr. Robert M. Ashley. I am a practicing osteopathic physician located at Wyandotte, Mich. My background includes a B. S. degree in chemistry at Denison University, the degree of doctor of osteopathy at the Kirksville College of Osteopathy and Surgery, internship at the college hospital, service in World War I, and since the war engaged in active practice in the State of Michigan. I am on the staff of the Riverside Osteopathic Hospital and served a term as a member of the Michigan Psychopathic Hospital Board.

The president of the American Osteopathic Association, Dr. John P. Wood, of Birmingham, Mich., and Dr. C. D. Swope, chairman of the department of public relations of the American Osteopathic Association, have deputized me to present to this committee our views and suggestions regarding the pending bills, H. R. 3174 and H. R. 3254, relating to procurement of physicians and surgeons for the Army and Navy, respectively.

There are approximately 11,000 osteopathic physicians licensed and practicing in the United States, about 9,000 of whom are members of the American Osteopathic Association. Practitioners of osteopathy are regularly licensed and practicing in all the States. In some 20 States they are licensed to practice the healing art in all branches. In most of the States they are licensed to practice major surgery. In a number of States applicants with the degree doctor of medicine and

applicants with the degree doctor of osteopathy take and pass the same State examination before the same State boards and receive the same or equivalent license.

There are six accredited colleges of osteopathy and surgery, all of which gear their training for the preparation of physicians who can pass the State board in any State and receive an unlimited license to practice the healing art. There are 58 accredited osteopathic intern-training hospitals. Both the schools and intern-training hospitals are inspected annually by the accrediting agency, the American Osteopathic Association, with a view to maintaining enforcement of high standards of training.

In order to obtain admittance to an osteopathic college a student must have completed at least 2 years in a liberal arts college and have obtained certain minimum credits in such subjects as chemistry, biology, physics, English, and so forth. If the candidate for admission can present those credentials and otherwise evidence the proper character and aptitude, he is admitted to a 4-year professional course in the osteopathic college, after which he undergoes an internship of 1 year in an accredited osteopathic intern-training hospital.

At this point I would like to include in the record an excerpt from the United States Office of Education guidance leaflet on osteopathy, which gives the standard minimum curriculum of approved osteopathic colleges. I will just include that in the record, if I may.

Mr. BLACKNEY. That will be included.

(The material is as follows:)

#### PREOSTEOPATHIC COLLEGE CREDITS REQUIRED

The minimum of 2 standard years (60 semester hours or an equivalent number of quarter hours) of successful preosteopathic college study required for entrance to the approved osteopathic colleges is 50 percent (one-half) of the total number of academic credits required for the conferment of the baccalaureate degree in arts or sciences in an approved college of liberal arts and sciences.

All osteopathic colleges require that the preosteopathic college study include credits in specified subjects, including chemistry, biology, physics, and English and, in some cases, others. The number of specified preosteopathic credits required by the different osteopathic colleges vary, as in other schools of medicine, but range from a minimum of 30 semester hours in one college to 46, plus 4 in physical education and health activities for students from its own State, in another.

All osteopathic colleges recommend, also, that certain subjects be included in preosteopathic college electives, and the laws governing licensure and practice in some States require that a modern foreign language be included.

#### STANDARD MINIMUM CURRICULUM OF APPROVED OSTEOPATHIC COLLEGES

The standard minimum curriculum in the approved osteopathic colleges, as arranged by the bureau of professional education and colleges of the American Osteopathic Association and the American Association of Osteopathic Colleges and adopted by the board of trustees, requires at least 4,000 hours over the standard four college years. Each year must have a minimum of 1,000 hours.

The subjects as grouped should have the proper relationship as to percentage of the entire time consumed in the standard 4-year course, and the courses in most osteopathic colleges consist of more than the required number of hours. The following schedule gives the approximate percentage of hours in relation to the whole course:

	Department	Percentage
1. Anatomy, including embryology and histology		18.5
2. Physiology		6.0
3. Biochemistry		4.5
4. Pathology, bacteriology, and immunology		13.0
5. Pharmacology		5.0
(Including, additionally, comparative therapeutics, materia medica, associated subjects.)		

	<i>Department</i>	<i>Percentage</i>
6. Public health		4. 0
	(Including, additionally, hygiene, sanitation.)	
7. Osteopathic medicine (principles, technique, practice)		26. 5
	(Including, additionally, neurology-psychiatry, pediatrics, dermatology and syphilology.)	
8. General surgery		17. 5
	(Including, additionally, orthopedic surgery, urology, otolaryngology, radiology.)	
9. Obstetrics and gynecology		5. 0

Textbooks approved for study in osteopathic colleges include the osteopathic texts dealing with the principles and practice of the distinguishing methods of osteopathy, plus texts as used in nonosteopathic medical schools.

The subject of medical therapeutics and the practice of medicine are covered as indicated above. The first 2 years of work are devoted chiefly to the basic sciences and include anatomy (descriptive histology, embryology, dissection), physiology, chemistry, pathology and bacteriology, supplementary therapeutics (toxicology, pharmacology, anesthesiology, narcotics, antisepsics), and biological therapeutics (vaccines, serums, antitoxins, etc.).

The last 2 years include hygiene and sanitation, practice of osteopathy, surgery, obstetrics, gynecology, etc., and include eye, ear, nose, and throat, nervous and mental diseases, public health, etc.

Upon graduation, the degree of D. O. (doctor of osteopathy) is conferred. Candidates for graduation in all approved colleges must be 21 years of age, and must have given a minimum number of osteopathic treatments.

Dr. ASHLEY. Notwithstanding this evidence of professional training as practitioners of the healing art, neither the Army nor the Navy has seen fit to utilize the professional services of osteopathic physicians and surgeons as commissioned officers in the Medical Corps, although numerous qualified applicants presented themselves to the Medical Departments of both services for commissions during the last two World Wars. Osteopathic physicians volunteered and were drafted during both wars. According to reports from the men who served, their professional training was ignored generally and they served as enlisted men in various branches of the Army. Some were assigned to the Medical Departments and in some of those instances they worked alongside doctors of medicine and rendered the same services, but in the noncommissioned ranks.

Testifying on the veterans' medical bill before the Veterans' Affairs Committee of the House of Representatives last Congress, Gen. Paul Hawley, chief medical officer of the Veterans' Administration, who was in charge of hospitals in the European theater during World War II, said he wanted the record to show that he used osteopathic physicians in the rehabilitation hospitals in the European theater of operations. Said he:

That service, in one hospital, was headed up by a man who was both a doctor of osteopathy and a doctor of medicine, and the men who worked under his supervision were doctors of osteopathy.

Of course, those osteopathic physicians were put on notice that regardless of the extent of their professional training and ability, they would not be commissioned in the Medical Corps. They knew before they entered the service; before the United States entered the war. On April 22, 1939, Dr. D. J. Tepper, an osteopathic physician, who had written the Surgeon General, received the following reply:

The Surgeon General has instructed me to state in reply that in the event of the United States becoming involved in any war the policy of the War Department would be, as in time of peace, to commission as officers in the Medical Corps of

the Army only those physicians who are graduates of recognized medical schools listed as such by the American Medical Association and authorized to confer the degree of doctor of medicine.

Yours very truly,

W. L. SHEEP,  
*Colonel, Medical Corps, Assistant.*

But those osteopathic physicians hoped in justice for a change in the Army medical policy. Congress also shared that hope, as evidenced by the fact that on June 30, 1941, Congress indicated that osteopathic graduates should be used by the Army, by providing—for the pay of interns who are graduates of or have successfully completed at least 4 years' professional training in reputable schools of medicine or osteopathy.

The purpose of Army internships is to train physicians for entry into the Medical Corps of the Army.

That provision first appeared in a military appropriation act, Public Law 139 of the Seventy-seventh Congress, and was written into substantive law effective for the duration, by Public Law 580 of the Seventy-ninth Congress. Following approval of the provision in 1941, the Surgeon General of the Army announced "Any senior in an osteopathic school of medicine may make such application for such internship, if he so desired. The appointment of these interns, however, will be made in November by the Surgeon General."

A number of qualified osteopathic seniors applied, but none were appointed and in November 1942 the Army Surgeon General announced that no more interns would be employed during the emergency.

Notwithstanding the Army internship law, the Adjutant General of the Army on June 2, 1942 wrote to an osteopathic applicant, Dr. Robert H. Conover, in terms the same as that written to other osteopathic applicants, stating, "There is no authority for appointment in the Medical Department or any other section of the Army of the United States for osteopathic physicians."

That statement apparently continues as the prevailing legal opinion of the Army, inasmuch as all osteopathic applications have been denied, which brings me to the first amendment which we have to propose to the pending bill, H. R. 3174.

Page 1, line 9, after the word "mean" insert the following  
citizens of the United States who hold the degree doctor of medicine or doctor of osteopathy from accredited colleges and universities who are.

That amendment if adopted would make clear that there is authority for appointment of osteopathic graduates as "commissioned officers of the Medical Corps." The amendment is in line with a similar provision which Congress enacted in connection with the Department of Medicine and Surgery of the Veterans' Administration, Public Law 293, Seventy-ninth Congress, approved January 3, 1946, section 5 of which reads in part as follows:

SEC. 5. Any person to be eligible for appointment in the Department of Medicine and Surgery must—

- (a) Be a citizen of the United States.
- (b) In the Medical Service \* \* \* hold the degree of doctor of medicine or of doctor of osteopathy from a college or university approved by the Administrator, have completed an internship satisfactory to the Administrator, and be licensed to practice medicine, surgery, or osteopathy in one of the States or Territories of the United States or in the District of Columbia."

I may say at this point that last December the Veterans' Administration announced that the osteopathic colleges and intern-training hospitals had been approved by the Veterans' Administrator and osteopathic applicants would be appointed, and I understand some have been so appointed and are serving.

This amendment is also in line with section 41 of Public Law 604, Seventy-ninth Congress, approved August 2, 1947, whereby the President is specifically authorized to appoint osteopathic graduates as commissioned medical officers in the Navy.

I am informed that osteopathic graduates have not yet been appointed as commissioned medical officers in the Navy, although the previous Surgeon General last fall was giving active consideration to and indicated their appointment as assistant surgeons.

Our next amendment occurs on page 5, line 14, after the word "male", insert "physicians who are". Also, after the word "States", insert a period and strike the remainder of the sentence.

This amendment does not expressly make doctors of osteopathy eligible for appointment to the professorships but would remove the language that debars their appointment.

The next amendment is on page 8, line 24. After the word "medicine", insert the words "or doctor of osteopathy."

This amendment insures eligibility of doctors of osteopathy and is in line with the Veterans' Administration law and the amendment proposed to title I of this bill.

The next amendment is on page 8, line 25. Strike the word "approved" and substitute the word "accredited."

This amendment is in line with the policy announced by the Army and Navy during the hearings on the Army-Navy Medical Services Corps Act of 1947, in which it was stated that it would be the policy of the Army and Navy to accept graduates from schools accredited by their respective professional associations.

We would also like to suggest that required recognition of American specialty boards by the Advisory Board for Medical Specialties, as stated on page 3, line 10, page 8, line 3, and page 9, line 20 and in H. R. 3254, page 5, line 3, be deleted, unless osteopathic representation is to be included on the advisory boards. Osteopathic physicians are certified as specialists by the American osteopathic specialty boards whose standards are comparable to the standards of the other American specialty boards.

I will include that list, or read it if you care to have me read it.

Mr. BLACKNEY. Include it in the record, will you, Doctor, please.

Dr. ASHLEY. Yes, sir.

(The list is as follows:)

#### BOARDS OF SPECIALTY CERTIFICATION

- American Osteopathic Board of Dermatology and Syphilology.
- American Osteopathic Board of Internal Medicine.
- American Osteopathic Board of Neurology and Psychiatry.
- American Osteopathic Board of Obstetrics and Gynecology.
- American Osteopathic Board of Ophthalmology and Otolaryngology.
- American Osteopathic Board of Pathology.
- American Osteopathic Board of Pediatrics.
- American Osteopathic Board of Proctology.
- American Osteopathic Board of Radiology.
- American Osteopathic Board of Surgery.

Dr. ASHLEY. I have here a list of the American osteopathic boards of specialty certification, which I would like to insert in the record. As an example concerning requirements for certification by these boards, I submit for the record a copy of the rules governing the American Osteopathic Board of Surgery.

I also have one which I can insert. It is quite lengthy and rather than read it I can just insert it in the record.

Mr. BLACKNEY. All right.

(The material is as follows:)

#### RULES CONCERNING REQUIREMENTS FOR CERTIFICATION

The American Osteopathic Board of Surgery will accept for examination for certification only osteopathic physicians who are specializing in one of the specialties under the jurisdiction of this board. The proportion of specialization in practice which is acceptable to the board may vary according to the size of the community and the conditions under which the applicant practices. The applicant must be engaged in the practice of general surgery or one of the specialty groups coming under the jurisdiction of this board, i. e., urology, orthopedics, or anesthetics, and he must present evidence satisfactory to the board that he is so practicing.

#### GENERAL SURGERY

Each applicant for certification under this board must present evidence that he has met the following minimum requirements:

1. He shall have been graduated from an approved osteopathic college for at least 7 years prior to consideration of his application by the board of examiners.
2. He shall have been a member in good standing of the American Osteopathic Association for a period of not less than 3 years and, if he is successful in passing his examinations, he shall remain a member in good standing in the American Osteopathic Association and his State or divisional society.
3. He shall be, and if certified continue to be, favorably known and recognized in his community and by his clientele as an osteopathic physician who is specializing in the practice of general surgery or a surgical specialty coming under the jurisdiction of this board and may publicize his affiliations only in an ethical manner.
4. He shall have had an internship of at least 1 year in a hospital acceptable to the board of surgery. If the applicant was graduated prior to 1942, he may furnish evidence of training of equal value satisfactory to the board of surgery in lieu of a recognized internship. The intern year of 9 months as prescribed by the selective service board during World War II shall be acceptable as fulfilling this requirement.
5. He shall provide notarized documentary evidence of at least 3 years first assistantship to a recognized surgeon or surgeons or by serving an approved residency of 3 years as determined by the board of surgery during which time he shall have assisted in the performance of at least 400 major surgical operations.
- For the purposes of this section, the term "first assistant" shall mean one who, in addition to acting as first assistant across the operating table from the surgeon, must have participated actively in the preoperative diagnostic procedures and in the postoperative care. Not more than one first assistant may be associated with a surgeon on any one given case.
6. He shall provide notarized documentary evidence that he has performed 200 major surgical operations in which he was the responsible surgeon.
7. He shall present evidence that he has postgraduate training in the basic sciences of anatomy, physiology, and pathology.
8. He shall present detailed case records acceptable to the board of surgery of 25 major surgical procedures in which he was the responsible surgeon and handled by him as a surgical problem within the past 3 years. These records shall include history, physical examination, routine laboratory work, special laboratory work, preoperative diagnosis, detailed finding, detailed operative procedure, postoperative diagnosis, progress notes, gross and histological description, and diagnosis of excised tissue and a case summary.
9. He shall make written application on a form provided by the board of examiners. A fee of \$25 shall accompany his application.
10. He shall provide letters of recommendation from two certified surgeons who are acquainted with the applicant's ability and who will vouch for his training and his character.

11. He shall be available for a personal interview at the first stated meeting unless receiving notice from the secretary that such an interview has been waived.

12. He shall demonstrate his fitness for certification in any other manner as may be required by the board of surgery.

13. The application, letters of recommendation, case reports, and application fee must be in the hands of the secretary on or before January 1 preceding the next annual meeting of the American Osteopathic Association.

14. If accepted, he shall send the balance of the \$100 examination fee to the secretary-treasurer before the oral and written examinations may be taken. No part of the examination fee may be returned. He must pass all examinations as required by these bylaws.

15. Applicants for certification by this board who graduated during or before 1926, who during the 10 years immediately preceding his application for certification has been recognized by the profession in his community as a specialist in the field of surgery and who meets the general requirements as to association membership, licensure, ethical standing etc., and who has maintained appropriate activity in the American Osteopathic Association organizational work, specialty group activity, hospital staff work, the pursuit of periodic postgraduate study, contribution to the professional literature, etc., or otherwise indicated his consistent interest and competence in his special field; if in the opinion of the credentials committee, the applicant has been so regarded, the board of surgery may waive written and oral portion of the examination and recommend the applicant to the board of trustees of the American Osteopathic Association for certification upon successfully passing the clinical part of this examination.

16. All applicants excepting those otherwise provided for in paragraph 15 must successfully pass all examinations as set forth in these rules.

#### ORTHOPEDIC SURGERY

1. An applicant for certification before the American Osteopathic Board of Surgery, in orthopedic surgery, shall have been graduated from an approved osteopathic college for at least 7 years prior to consideration.

2. The applicant shall be a member in good standing of the American Osteopathic Association and his divisional osteopathic societies, for not less than 2 years prior to examination.

3. He shall be known and recognized in his community and by his colleagues as an osteopathic physician who is specializing in the practice of orthopedic surgery, and shall publicize his osteopathic affiliations in an ethical manner. It is considered the applicant shall devote enough of his practice exclusively to orthopedic surgery to satisfy the board's requirements for the community wherein he is practicing.

4. He shall have had an internship of at least 1 year in a hospital acceptable to the board of examiners. If the applicant was graduated prior to 1942, he may furnish evidence of training of equal value satisfactory to the board of examiners in lieu of a recognized internship. The intern year of 9 months as prescribed by the Selective Service Board during World War II shall be acceptable as fulfilling this requirement.

5. He shall present notarized documentary evidence of at least 3 years' assistantship to a certified orthopedic surgeon or surgeons or certified general surgeons or surgeons, during which time he shall have assisted in the performance of at least 400 major surgical procedures, 200 of which must be orthopedic procedures, or in lieu thereof he shall present notarized documentary evidence of assistantship to a certified osteopathic orthopedic surgeon, or a surgeon recognized in his community as a qualified orthopedic surgeon, during which time she shall have assisted in the performance of at least 400 orthopedic surgical procedures during a period of not more than 5 years.

6. He shall have practiced orthopedic surgery as a specialty in all its branches for a period of at least 5 years, during which time he shall have performed at least 200 major orthopedic procedures, and shall present documentary proof thereof, before presenting himself for examination before the board. In addition, he shall submit a record of his surgical cases for the year immediately preceding the date of examination, showing the date, hospital case number, name of assisting surgeon, diagnosis, and operative procedure.

7. He shall provide evidence that he has received basic training of postgraduate level in anatomy, physiology, and pathology pertinent to orthopedics and satisfactory to the board of examiners.

8. He shall demonstrate his fitness to take the examination in any other manner that may be required by the board of surgery.

9. He shall present 25 detailed case reports (records) with his application to the board, of major orthopedic procedures, in which he was the responsible surgeon.

10. The applicant shall make written application on a form provided by the American Osteopathic Board of Surgery, in accordance with the rules governing applications.

11. The applicant shall present letters of recommendation from two or more certified surgeons who are personally acquainted with the applicant, and who will vouch for his surgical training, surgical experience, personal character, and who have personally observed the surgical skill of the applicant. The sponsors shall send their letters of recommendation direct to the secretary of the American Osteopathic Board of Surgery.

12. No applicant may be approved for examination who is certified by another certifying board except that he has expressed his intent to qualify for transfer from his former certification.

13. Applicants for certification by this board who graduated during or before 1926, who during the 10 years immediately preceding his application for certification has been recognized by the profession in his community as a specialist in the field of surgery and who meets the general requirements as to association membership, licensure, ethical standing, etc., and who have maintained appropriate activity in the American Osteopathic Association organizational work, specialty group activity, hospital staff work, the pursuit of periodic postgraduate study, contribution to the professional literature, etc., or otherwise indicated his consistent interest and competence in his special field. If in the opinion of the credentials committee the applicant has been so regarded the board of surgery may waive written and oral portion of the examination and recommend the applicant to the board of trustees of the American Osteopathic Association for certification upon successfully passing the clinical part of this examination.

#### UROLOGICAL SURGERY

Each applicant for certification under this board must present evidence that he has met the following minimum requirements:

1. He shall have been graduated from an approved osteopathic college for at least 7 years prior to consideration of his application by the board of examiners.

2. He shall have been a member in good standing of the American Osteopathic Association for a period of not less than 3 years, and, if he is successful in passing his examinations, he shall remain a member in good standing in the American Osteopathic Association and his divisional or local society.

3. He shall be, and if certified continue to be, favorably known and recognized in his community and by his clientele as an osteopathic physician who is specializing in the practice of urological surgery and shall publicize his affiliations only in an ethical manner.

4. He shall have had an internship of at least 1 year in a hospital acceptable to the board of examiners. If the applicant was graduated prior to 1942, he may furnish evidence of training of equal value satisfactory to the board of examiners in lieu of a recognized internship. The intern year of 9 months as prescribed by the Selective Service Board during World War II shall be accepted as fulfilling this requirement.

5. He shall provide notarized documentary evidence of at least 3 years' first assistantship to a recognized surgeon or surgeons as determined by the board of examiners during which time he shall have assisted in the performance of at least 400 major operations, 200 of which must be of a major urological nature.

For the purposes of this section, the term "first assistant" shall mean one who, in addition to acting as first assistant across the operating table from the surgeon, must have participated in the work-up study of the case and must have been associated with the surgeon in the after care. Not more than one first assistant may be associated with a surgeon on any one given case.

6. He shall provide notarized documentary evidence that he has performed 200 major surgical operations in which he was the responsible surgeon. One hundred of these must be of a major urological nature.

7. He shall present evidence that he has had satisfactory postgraduate training in the basic sciences of anatomy, physiology, and pathology.

8. He shall present detailed case records acceptable to the board of examiners of 25 major urological surgical procedures in which he was the responsible surgeon and handled by him as a surgical problem within the past 3 years. These records shall include history, physical examination, routine laboratory work, special

laboratory work, preoperative diagnosis, detailed findings, detailed operative procedure, postoperative diagnosis, progress notes, gross and histological description, and diagnosis of excised tissue and a case summary.

9. He shall make written application of a form provided by the board of examiners. A fee of \$25 shall accompany his application.

10. He shall provide letters of recommendation from two certified surgeons who are acquainted with the applicant's ability and who will vouch for his training and his character.

11. He shall be available for a personal interview should such an interview be deemed necessary by the board of examiners.

12. He shall demonstrate his fitness for certification in any other manner as may be required by a board of examiners.

13. The application, letters of recommendation, case reports, and application fee must be in the hands of the secretary on or before February 1 preceding the next annual meeting of the American Osteopathic Association.

14. If accepted, he shall send the balance of the \$100 examination fee to the secretary-treasurer before the oral and written examination may be taken. No part of the examination fee may be returned. He must pass all examinations as required by these bylaws.

15. Applicants for certification by this board who graduated during or before 1926, who during the 10 years immediately preceding his application for certification has been recognized by the profession in his community as a specialist in the field of surgery and who meets the general requirements as to association membership, licensure, ethical standing, etc., and who has maintained appropriate activity in the American Osteopathic Association organizational work-specialty group activity, hospital staff work, the pursuit of periodic postgraduate study, contribution to the professional literature, etc., or otherwise indicated his consistent interest and competence in his special field. If in the opinion of the credentials committee the applicant has been so regarded, the board of surgery may waive written and oral portion of the examination and recommend the applicant to the board of trustees of the American Osteopathic Association for certification upon successfully passing the clinical part of this examination.

#### ANESTHESIOLOGY

A subsidiary examining board, under the auspices of the American Osteopathic Board of Surgery, will function under the accepted general bylaws of the latter board in that it shall govern the organization as follows: The selection of the board personnel, the time and place of meeting, and the modus operandi of candidate examination. Moreover, it shall dictate such general duties and requirements of the applicant as may apply to all candidates petitioning for specialty certification.

Specific duties and requirements for certification of the applicant in the specialty of anesthesiology are as follows:

1. The applicant must have graduated from a recognized osteopathic college and be duly licensed as a physician and surgeon in the State in which he conducts his specialty practice.

2. An applicant graduated after 1942 must have served a year's internship in a hospital recognized by the American Osteopathic Board of Surgery. If he were graduated prior to 1942 and served no internship, he must have spent 3 years in general practice before taking up the practice of anesthesiology.

3. The applicant graduated prior to 1945 must have served a period of formal training or fellowship in anesthesiology of 1 year's duration in a hospital recognized by the American Osteopathic Board of Surgery to provide such training. In lieu of the above requirement, the applicant must have spent 5 years in the practice of anesthesiology each year of which he administered at least 350 anesthetics of a diversified nature.

4. All applicants must have practiced the specialty of anesthesiology for 3 years prior to application (this is in addition to the fellowship of 1 year or the 5-year specialty-practice period in lieu of fellowship.) During each of these 3 years the applicant must certify that he has administered at least 350 anesthetics of a diversified nature.

5. Submit to the secretary reprints or copies of articles pertaining to anesthesiology written by the applicant.

6. Submit 25 major anesthetic records, in book form, using an outline which correlates the principal details of preoperative, operative and postoperative

conduct of the anesthesia. (A sample outline may be secured from the secretary upon request.)

7. Submit complete case records and report all pertinent factors and explanation of the cause of the outcome on any fatalities anesthetized by the applicant which occurred under 24 hours of the end of anesthesia. (An outline may be secured upon request.)

8. Submit a segregated total of all anesthetics administered by the applicant in the 3-year period prior to making application, thereby showing the variety of agents and methods of anesthesia.

9. Applicants for certification by this board who graduated during or before 1926, who during the 10 years immediately preceding his application for certification has been recognized by the profession in his community as a specialist in the field of surgery, and who meets the general requirements as to association membership, licensure, ethical standing, etc., and who has maintained appropriate activity in the American Osteopathic Association organizational work, specialty-group activity, hospital staff work, the pursuit of periodic postgraduate study, contribution to the professional literature, etc., or otherwise indicated his consistent interest and competence in his special field; if in the opinion of the credentials committee, the applicant has been so regarded, the board of surgery may waive written and oral portion of the examination and recommend the applicant to the board of trustees of the American Osteopathic Association for certification upon successfully passing the clinical part of this examination.

#### RULES OF CONDUCT OF EXAMINATIONS BY THE AMERICAN OSTEOPATHIC BOARD OF SURGERY

1. The following rules shall govern all examinations in all fields coming under the jurisdiction of the board of surgery.

2. The examination shall be so designed, constructed, and conducted that any practicing osteopathic physician who is recognized in his community by his colleagues and the laity as a surgical specialist within the fields covered by this board as defined in these articles would be expected to pass.

3. Emphasis should be placed on trying to obtain a clear idea, upon the part of the examining board, of the applicant's ability, capability, and attainments.

4. Each applicant should be thoroughly acquainted with the definition of the specialty of surgery in which he is being examined, and the scope of practice it covers, and thoroughly acquainted with the code of ethics governing the practice of surgery as approved by the American Osteopathic Association.

5. There shall be three phases of each examination: Part I: Review of credentials and personal interview; part II: oral and written; part III: clinical or practical. Each succeeding phase of the examination must be successfully passed before the applicant may proceed to the next.

#### RULES GOVERNING THE EXAMINATION ITSELF

##### Part I. Examination of credentials and oral interview.

This phase of the examination is conducted by the board of surgery at the annual meeting or at any special meeting called for that purpose. Oral interview is required only of those applicants who have not been excused by the credentials committee.

##### Part II: Oral and written examination:

**Oral:** This phase of the examination shall be conducted as a round-table discussion wherein the chairman of the examining committee will introduce the discussion of practical clinical problems; the number of applicants present at any one discussion is not to exceed four. The questions would by turns be directed toward individual applicants with all other applicants expected to enter into the discussion, the members of the examining committee interjecting questions at any time. The examining committee shall use only the material prepared and approved by the board of surgery.

**Written:** There shall be two parts to the written, consisting of two sets of six questions from which the applicant answers five from each set. At least 10 minutes intermission must elapse between parts 1 and 2.

## RULES GOVERNING GRADING ORAL AND WRITTEN

The oral and written examination shall be averaged and considered as one examination, each being considered of equal value.

At all oral examinations the personnel of the examining committee should, if practical, be such that each of the time belts should be represented on the committee.

All written examination papers shall be read and graded, if practical, by one examiner from each of the time belts.

All questions on the written shall be graded on the basis of 10 points representing perfect and the total of parts 1 and 2 representing the grade.

For the oral, each candidate shall be graded on the basis of 10 being perfect for each subject brought up for discussion. The total for all questions discussed shall be determined and multiplied by 10. This number is to be divided by the number of subjects discussed and the answer considered as the grade.

The oral grade and written grade are added and the sum divided by two for the final grade. Seventy-five average is considered passing.

## CLINICAL EXAMINATION RULES

Upon notification to the applicant that he has passed the second part of the examination and notification of his examining committee personnel, the applicant shall arrange a time and place for the clinical examination and notify his committee.

The clinic shall consist of not less than three major operations of a diversified character in the field being covered by the applicant.

The applicant must furnish to his examining committee a copy of the case history including all preoperative diagnostic procedures, the operating technique, and condition of the patient upon discharge from hospital.

The clinical examining committee will record passed or failed, and forward these records to the chairman of the examining committee for the specialty being covered.

These records will be forwarded to the examination committee for review and certification by the board of surgery at its next stated meeting.

## RULES OF PROCEDURE FOR THE APPLICANT FOR EXAMINATIONS BY THE AMERICAN OSTEOPATHIC BOARD OF SURGERY

1. The applicant procures from the secretary all of the blanks and information covering his special field.
2. The applicant files his application with the secretary before the closing date.
3. The applicant presents himself for oral interview when and if requested to do so by the secretary upon recommendation of the credentials committee.
4. The applicant presents himself for oral and written examination at the time and place designated.
5. The applicant arranges for satisfactory clinical or practical examination as directed by the secretary of the board of examiners.

## RULES GOVERNING REEXAMINATION

No applicant will be reexamined within a period of 1 year following an initial failure. Reapplication will be necessary to retake the examination. If the applicant fails the second examination, a 2-year period of further specialty study and practice satisfactory to the board of examiners must elapse before becoming eligible to reapply for examination.

## AMENDMENTS

These rules may be amended at any stated or called meeting by a majority vote of the board membership.

Mr. BLACKNEY. Doctor, that is a fine statement, but I would expect it to be because you come from my home State of Michigan.

What is the over-all number of years it takes to qualify as a doctor of osteopathy? What is the term of years?

Mr. ASHLEY. Two years pre-med and four years in an accredited college, with a year of internship.

Mr. BLACKNEY. An over-all period of 7 years.

Dr. ASHLEY. Yes, sir.

Mr. BLACKNEY. Including the internship.

Dr. ASHLEY. That is right.

Mr. BLACKNEY. Any questions?

Mr. HÉBERT. No.

Mr. SHAFER. Doctor, from your statement I gather that you feel there is discrimination against the osteopath within the Medical Department of the War Department?

Dr. ASHLEY. Well, I believe so. I served in the First World War and would gladly do it again if I had to. I have felt that we have rendered a service to the civilian populace and I believe that same service could go into the military, with an advantage to the boys who are in the service. We would be working in our highest degree of education, that is, our highest skill, if they would let us work there.

Mr. SHAFER. You brought out the fact that many osteopaths were used during the last war in the European theater and other theaters of war.

Dr. ASHLEY. Yes.

Mr. SHAFER. I was in England and visited hospitals in England during the war. I saw considerable of the work that was being done there to rehabilitate the wounded. That, I take it, was being done by osteopaths—that is, the various exercises that they were going through and the various manipulations of muscles to correct the difficulties the injured boys were having, is that true?

Dr. ASHLEY. Yes.

Mr. SHAFER. As a result of that, Doctor, isn't it quite natural that some of these veterans who are still in the Army hospitals or who are in the Veterans' Administration hospitals would like to have the services of osteopaths?

Dr. ASHLEY. They have asked for it.

Mr. SHAFER. They request it right along, do they?

Dr. ASHLEY. Yes.

Mr. SHAFER. Now, are there any osteopaths in the Army General hospitals?

Dr. ASHLEY. In the Army hospitals?

Mr. SHAFER. In the Army general hospitals today?

Dr. ASHLEY. Not practicing as osteopaths.

Mr. SHAFER. Are they in the Veterans' Administration?

Dr. ASHLEY. They are in the Veterans' Administration. There are some just breaking into the Veterans' Administration. That is due to this law that I referred to, which was passed just recently.

Mr. SHAFER. That is all.

Mr. BLACKNEY. Thank you, Doctor —

Mr. SHAFER. One further question. Are these osteopaths that are being used now, Doctor, being used part-time or full time in the Veterans' Administration?

Dr. ASHLEY. Full time.

Mr. SHAFER. Full time.

Dr. ASHLEY. Yes, sir.

Mr. SHAFER. There is apparently no discrimination there at all.

Dr. ASHLEY. No.

Mr. SHAFFER. In the Veterans' Administration.

Dr. ASHLEY. That is right.

Mr. SHAFFER. Doctor, would you mind submitting a list, within your remarks, of where these osteopaths are being employed at the present time in the Veterans' Administration?

Dr. ASHLEY. I didn't submit it; but I will submit it.

Mr. SHAFFER. I wish you would.

Dr. ASHLEY. I will; yes, sir; thank you.

Mr. BLACKNEY. Thank you, Doctor.

For the record I want to make this statement, on the expense of the bill, and if any of the departments here have a different figure I wish you would let me know.

The over-all expense of the Army Medical Corps under this bill would be approximately \$4,288,000; the Navy, \$3,752,000; and the Public Health Service, \$1,199,000—totalling \$9,240,000.

Now, should the dentists be incorporated in the bill, that would add to the Army \$1,440,000; to the Navy, \$1,179,000; and to the Public Health Service, \$250,000.

Is there any one else that desires to be heard?

(No response.)

If not, the committee will go into executive session.







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